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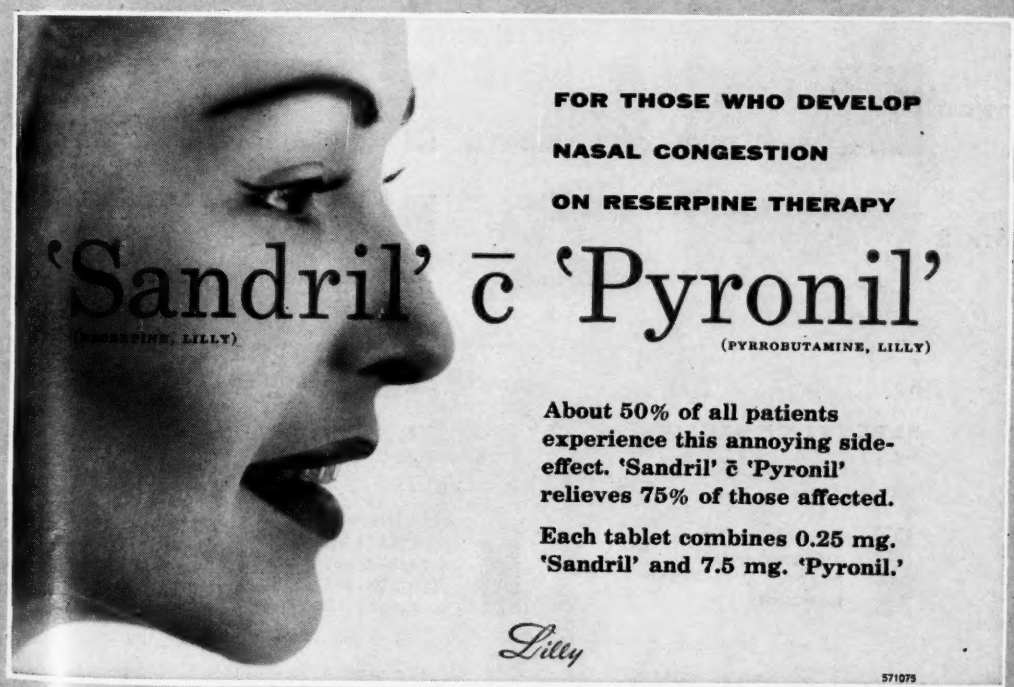

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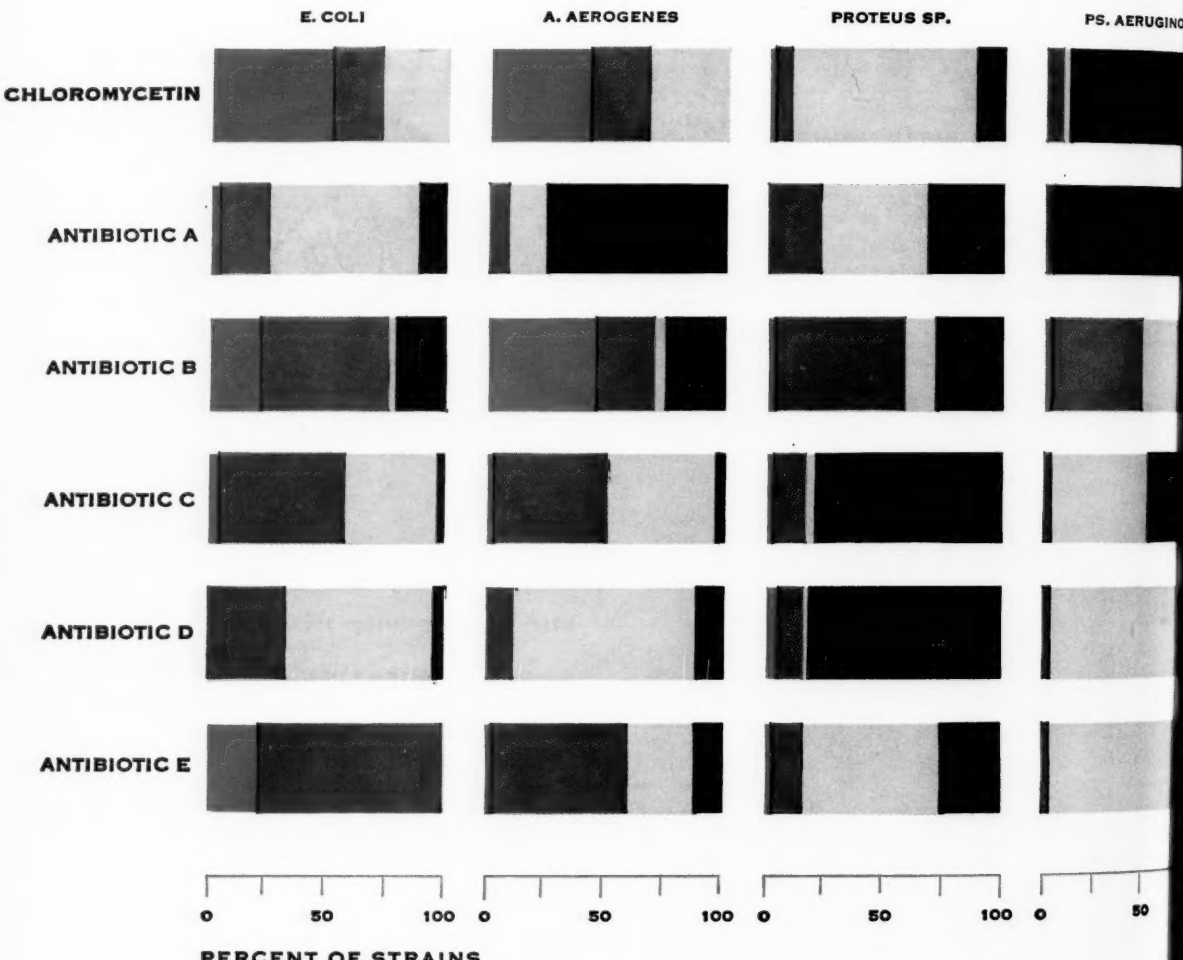

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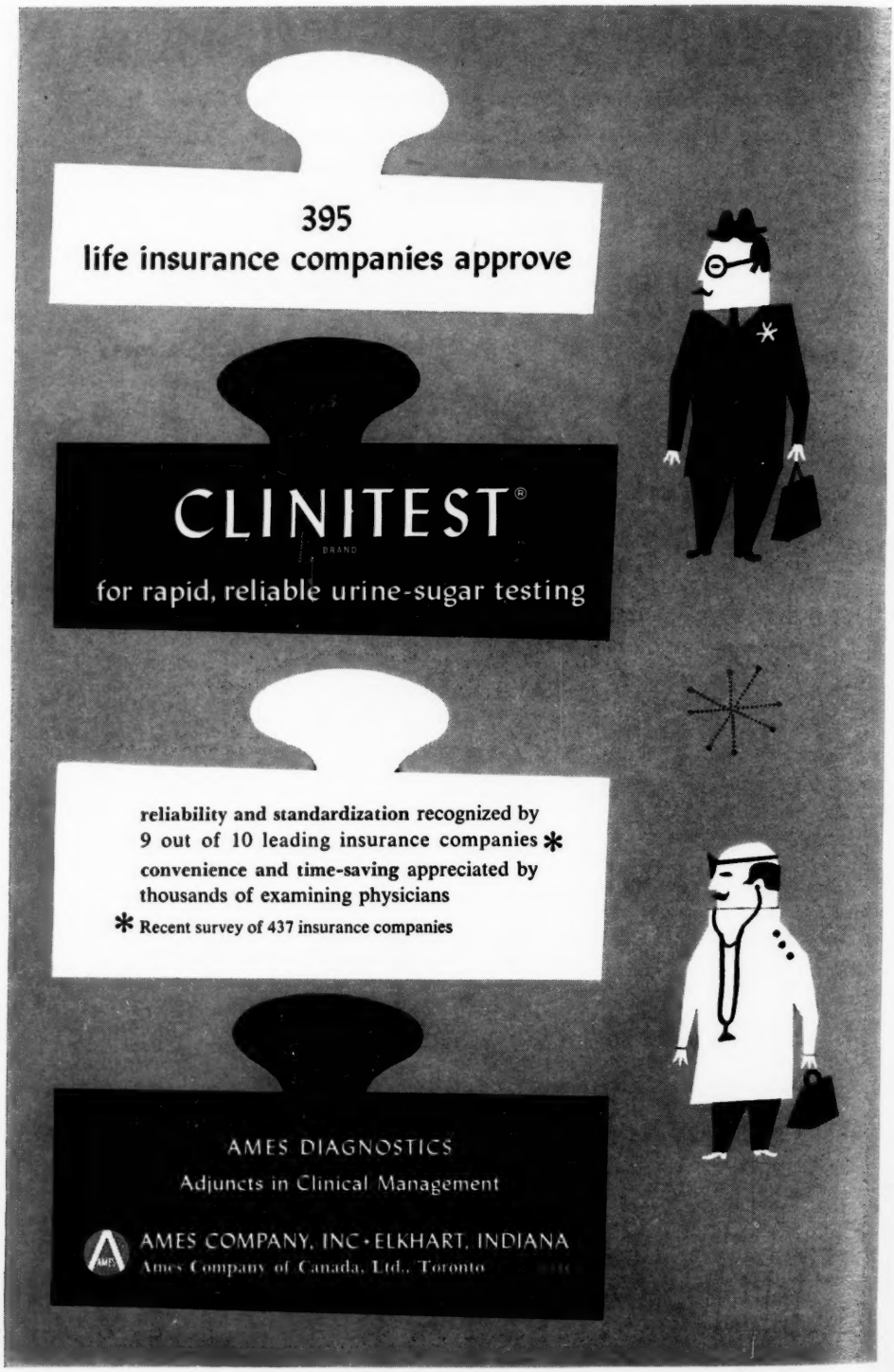
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The RHODE ISLAND MEDICAL JOURNAL

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SEGMENTAL ARTERIAL OCCLUSIONS TREATED WITH RESECTION AND GRAFTING*

STEWART ARMSTRONG, M.D.

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THE SURGERY of arterial occlusive disease has advanced rapidly during the past few years. It now appears that replacement of occluded segments with grafts offers the best possibility for success. The ideal graft has probably not yet been found, but it seems likely that flexible plastic tubes will prove to be the most satisfactory in the future. Recent experimental reports by Deterling, et al[1] and Hufnagel[2] are encouraging. At the present time, we have no clinical experience in humans with artificial blood vessel prostheses. Because of the availability of an arterial bank, our experience is limited to the use of homologous arterial grafts and autogenous vein grafts. In the use of autogenous vein grafts, we have employed the methods described by Julian and Dye.[3] Homogenous vein grafts have not been required to date. The arterial bank employs the frozen state method of preservation of homologous arteries described by Gross.[4]

The ideal candidate for resection and arterial grafting described by Robb,[5] Julian and Dye,[3] and Szilagyi,[6] is the patient with pure segmental arteriosclerotic occlusion and with intermittent claudication as the primary symptom. Rest pain, trophic changes such as ulceration and gangrene represent artereolar involvement and therefore have been said to represent contra-indications to surgery.

In the patients discussed in this report, segmental occlusions were found to be associated with generalized arteriosclerotic changes, and no pure segmental blocks were identified. One of the patients had intermittent claudication as the primary complaint and the remainder had advanced signs of artereolar disease which includes severe rest pain, ulceration, and gangrene.

The purpose of this study is to evaluate the results of arterial grafting when these methods are applied to the advanced arteriosclerotic patient with proven segmental occlusions. With the exception of one, all of these patients were facing inevitable amputation at the time of arterial grafting. Thrombo-endarterectomy has been abandoned except for short segment iliac occlusions.

Methods

Femoral Arteriography and Aortography. Angiographic techniques are carried out under intravenous Pentothal and Leucine sensory spinal anesthesia. A fractionation technique of obtaining X-ray exposures is used as described by Langsam and Wilansky.[7]

Aortography is performed using a two-needle (18 gauge thin) technique for simultaneous injections. We employ Sodium Acetrizoate (Urokon Sodium) 70% as the radiopaque medium. Femoral arteriography is carried out by the percutaneous route using an 18 gauge thin needle and 35% Urokon solution. X-ray films are exposed at three- to four-second intervals. If satisfactory visualization of the popliteal and anterior and posterior tibial arteries is not obtained on the first injection, a repeat injection is carried out. If satisfactory visualization of the femoral and lower leg vessels is not obtained by fractionation aortography, femoral arteriograms are obtained.

Operative Technique. Positioning of the patient on the operating table has varied depending on the site of the block. The supine position with flexion of the involved extremity employing the Henry approach to the vessels has been used largely. An exaggerated Sims position with the opposite extremity hyperflexed on the trunk has proved a very satisfactory approach to the femoral and popliteal vessels. In half of the cases, after division above and below the block, the occluded segment has been

continued on next page

*From the Boston University Teaching Service (Third Surgical), Boston City Hospital. Presented at the Reunion Day of the St. Joseph's Hospital Staff Association, at Providence, Rhode Island, September 7, 1955.

ligated at each end and left in situ. In the other half, the occluded segment was resected for technical reasons. End-to-end anatomoses employing an everting interrupted suture of #00000 silk were used in all but one case. In this instance, a shunt type of graft with end-to-side anastomosis proximal and distal to the occlusion was employed. Where autogenous saphenous vein was used, the vein was reversed prior to implantation. The segments replaced are shown in Table I. Anticoagulant therapy was not used as a routine postoperative measure.

TABLE I
Segments Replaced or Bypassed

Aortic bifurcation	1
Common Iliac to Femoral	1
External Iliac to Common Femoral	1
Superficial Femoral	5
Femoral to Popliteal	1
Subclavian	1

Type of Grafts. The distribution of types of graft employed is seen in Table II. Autogenous saphenous vein was used in six patients. However, in one of these because of incomparability at the upper end, it was necessary to insert a short segment of superficial femoral vein in order to complete the anastomosis. Homologous artery was used in four instances and this was obtained from the artery bank in frozen state. These vessels are taken in the autopsy room under unsterile conditions and after being placed in a double-sealed Polyethylene envelope quick frozen in dry ice and placed in the deep freeze. While kept in the frozen state, the vessels are sterilized under the two million volt cathode ray machine at Massachusetts Institute of Technology. The graft is prepared at operation by thawing in normal Saline and ligating all branching vessels with #00000 silk.

TABLE II
Type of Graft and Results

	Good	Failure
Autogenous Saphenous Vein	4	2
Homologous Artery	2	2

Age of Patient. The patients varied in age from 52 to 76 years with an average age of 64 years. There were eight males and two females in the series.

Report of Cases

The following case summaries will serve to indicate the multiplicity of problems involved.

Case I. J.D. A sixty-five-year-old white male diabetic of long standing entered the hospital on May 3, 1955, with wet diabetic gangrene of the left third toe of five weeks' duration. On a previous admission two years ago, left lumbar sympathectomy had been recommended but refused by the patient. A lumber sympathetic block produced very slight warming of one to two degrees on the left side. Left lumbar sympathectomy and amputation of the third toe was carried out on May 11th without appreciable improvement in the circulatory status of the foot. Left femoral arteriogram at the same time revealed an arteriosclerotic occlusion of the entire superficial femoral artery from the profunda take-off to the popliteal. Because of arterial insufficiency in the opposite foot, an aortogram was performed on May 25th which again showed the occlusion of the superficial femoral on the left. There was generalized arteriosclerosis with considerable narrowing of the right superficial femoral artery but the vessels were grossly patent. The amputation site of the left third toe remained necrotic and septic and gangrene spread to involve the second toe. On June 6, 1955, the left superficial femoral artery was replaced from the origin of the profunda to the popliteal with an autogenous saphenous vein graft. The occluded artery was left in situ. Post-operatively, the left foot was warm and pedal pulses have continued until the present. The gangrenous left second toe was amputated on June 19, 1955. In spite of the return of pedal pulses and warming of the foot, the already present infection and necrosis at the amputation stumps failed to heal. On August 19, 1955, a left transmetatarsal amputation was performed coincidental with a right lumbar sympathectomy. A satisfactory result has been obtained thus far.

In view of the advanced state of artereolar disease associated with long-standing diabetes, this man was most certainly facing mid-thigh amputation prior to arterial grafting. Trans-metatarsal amputation would probably have failed without this procedure.

Case II. H.N. A sixty-year-old white male tabetic retired policeman entered the hospital on March 28th because of large gangrenous trophic ulcers over both lateral malleoli. His physiological age was estimated at approximately eighty. He had been completely incapacitated at home in a chair for the past two years. He had been unable to walk because of tabes and the trophic ulcers of one year's duration. In spite of multiple operative procedures including bilateral lumbar sympathectomy and repeated skin grafting of the ulcer areas, healing failed to take place. Left femoral arteriogram on April 5, 1955, showed occlusion of the left distal femoral and popliteal arteries. This vessel was replaced with an autogenous saphenous vein graft without resection of the block segment on June 23, 1955. Immediately following operation, there was marked improvement in the temperature of the foot and the anterior tibial pulse was felt and has continued. Subsequently the ulcer over the left lateral malleolus was grafted and has almost completely healed at present. Unfortunately, arterio-

grams of the right leg show generalized narrowing but no discrete occlusion. The trophic ulcer over the right lateral malleolus has increased in size and a large ulceration has now occurred over the heal of the right foot.

Although the follow-up interval is only ten weeks, preservation of the left leg appears to have been accomplished. However, the right leg will undoubtedly come to amputation in the near future.

Case III. H.N. A fifty-four-year-old white male who entered the hospital on June 22, 1955, because of severe ischmic rest pain in the right foot of one month's duration. Nine years previously, a right lumbar sympathectomy is said to have been performed for "Berger's Disease." One year prior to admission, the patient had had a cerebral vascular accident with a transient right hemiplegia associated with hypertension. Since onset of symptoms one month ago, he had been unable to walk far enough to determine the presence of intermittent claudication. Examination revealed coolness of the right foot. There were no pulses palpable below the femoral on the right side. A right femoral arteriogram on June 23, 1955, revealed a five-inch block of the right superficial femoral artery. On June 29, 1955, an autogenous saphenous vein graft to the right femoral artery was carried out without resection of the block segment. Post-operatively, there was symptomatic improvement and pedal pulses were noted for the first six post-operative days. At this time, the wound was found to be grossly septic. Deteriorization of circulation occurred and the right foot gradually became gangrenous. Mid-thigh amputation was performed on August 8, 1955. The amputated specimen showed patency of the autogenous vein graft, but thrombosis of the popliteal and tibial vessels.

What appeared to be a satisfactorily functioning vein graft for six days became a failure in this case probably due to massive sepsis which resulted in distal thrombosis.

Case IV. G.G. A seventy-year-old white female diabetic of thirty years' duration. She entered the hospital because of infection of the left great toe and marked arterial insufficiency of the left as well as the right foot. Eight years previously, amputation of the right fourth toe and left second toe had been performed because of infection. Examination revealed infection of the left great toe and absence of pedal pulses bilaterally. A left lumbar sympathectomy had been performed in 1944 and she had had a previous hospital admission for myocardial ischemia one year previously. On February 24, 1955, a left femoral arteriogram revealed an occlusion of the distal left femoral artery. This was resected and replaced with an autogenous vein graft on March 1, 1955. Post-operatively, there was considerable warming of the left leg and foot and healing of the skin lesions was taking place. She suddenly expired on the sixth post-operative day and was thought to have had a myocardial infarction. However, autopsy was not obtained.

This patient was accepted as an extremely poor cardiac risk for surgery. Since she was facing a major amputation, arterial graft was thought worth while. At the time of sudden death, the graft was functioning well and healing of the long-standing infection of the foot was taking place.

Case V. M.McD. A seventy-four-year-old diabetic of long standing entered another hospital because of severe ischemic pain of the entire right foot. She also had a 3 cm. deep gangrenous ulcer of the right heel which was extremely painful. Physical examination revealed a thin cyanotic extremely tender right foot with absence of peripheral pulses below the femoral. On January 1, 1955, a right lumbar sympathectomy was performed which afforded absolutely no relief in the rest pain. The gangrenous ulcer of the heel spread and deepened considerably. Right femoral arteriogram on January 12, 1955, revealed complete occlusion of the superficial femoral artery. However, a popliteal vessel of satisfactory caliber was finally visualized after repeat arteriograms. On January 26, 1955, the entire right superficial femoral artery was replaced with an autogenous saphenous vein graft. The saphenous vein at the proximal anastomosis was too small and therefore a segment of superficial femoral vein was used to make up the proximal end of the graft and the proximal anastomosis. Following operation, rest pain was completely relieved. There was marked increase in the temperature of the foot with the color returning to normal. Pedal pulses could not be felt. At the time of discharge from the hospital four weeks later, the heel ulcer had almost completely healed and the patient continued to be free of pain.

With symptomatic improvement and healing of the trophic ulcer as the only criterion for considering this a satisfactory result, it must be pointed out that this patient's limb has been preserved until the present. This is an eight-month period of follow-up and she most certainly faced mid-thigh amputation prior to arterial replacement.

Case VI. R.C. A fifty-two-year-old white male was first seen at an out-of-town hospital at midnight on May 23, 1954. At 3:30 P.M. that afternoon, he had been awakened while sitting in a chair by a severe cramp in the left foot. When admitted to the hospital two hours later, the left leg was cold and cyanotic to the level of the knee. At this time, the examining physician could obtain no pulses below the left femoral. When seen at midnight, no pulses were present below the inguinal ligament on the left. An iliac pulsation could be felt. There

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was numbness and loss of sensation and coldness to the level of the knee. There was no history of previous myocardial infarction or auricular fibrillation. Pre-operative impression was that an acute arterial thrombosis of the left iliac and common femoral artery had taken place. At operation, the distal left iliac and common femoral arteries were found to be occluded by fresh thrombus at the site of a long arteriosclerotic plaque. The artery was resected from the bifurcation of the iliac to just proximal to the profunda femorus artery. An autogenous saphenous vein graft was used. However, prior to completing the distal anastomosis, a retrograde flush with heparin solution was attempted at the posterior tibial artery at the ankle. This was unsuccessful and no solution could be forced through the bloodless posterior tibial artery. The reason for this became apparent on exploring the popliteal artery which was found to be completely occluded and apparently of long-standing. Therefore, the distal anastomosis was completed, and a left lumbar sympathectomy performed. Post-operatively, there was considerable improvement in the circulation of the foot. The color became pink and the temperature increased. However, where the arteriotomy had been performed for retrograde flush just posterior to the medial malleolus, the wound edges became gangrenous and gradually spread. Three months later, a left mid-thigh amputation was performed.

This case brings out the generally accepted poor prognosis for sudden thrombotic occlusion of a major artery. The results might have been different had there not been a previous segmental occlusion of the popliteal artery. This extremity might have survived had not gangrene developed at the site of posterior tibial artery retrograde flush wound. This represents an unforeseen technical error.

Case VII. C.C. A sixty-three-year-old white male who entered the hospital because of increasing coldness of the left foot on March 22, 1955. The foot had become red and tender a few days before admission. There was a past history of repeated admissions to the hospital for acute and chronic alcoholism and two years previously, a cerebral vascular accident left him with complete aphasia and dysarthria. Examination revealed marked tenderness in the left foot with rubor and cyanosis on dependency. On March 23, 1955, translumbar aortogram revealed complete occlusion of the left external iliac artery. Left lumbar sympathectomy performed on March 28th afforded only slight relief of pain and no objective evidence of improvement in circulation. Resection of the left common iliac and external iliac artery was carried out from 2 cm. distal to the aortic bifurcation to just proximal to the origin of the profunda femorus artery on May 9, 1955. Replacement was accomplished with a long arterial homograft. Following operation, there was complete relief of symptoms. The left foot became warm and a good posterior tibial pulsation could be felt. Gangrene of the left great toe which had occurred prior to arterial grafting gradually healed by the time of discharge on June 29, 1955. During this hospitalization, a right lumbar sympathectomy was also carried out for arterial insufficiency of the right leg with considerable improvement. Because of persistent posterior tibial pulsation on the left, post-operative arteriograms were not performed.

By all standards, this man represented a poor risk for surgery of any kind. However, a good result has been obtained over a five-month follow-up.

Case VIII. S.S. A sixty-eight-year-old white male whose primary complaint on March 9, 1955, was intermittent claudication of two years' duration. Calf muscle pain occurred on the left after five minutes of walking and on stopping, the pain lasted for approximately five minutes before relief was obtained. During the previous year, he had been treated with Priscoline and had had twenty-eight chiropractic treatments without benefit. On examination, both feet were cool and on the left side, there was dependency cyanosis. Dorsalis pedis and posterior tibial pulsations were absent on the left. A faint popliteal and a good femoral pulse was present on the left side. Good pedal pulses were obtained on the right. Left femoral arteriogram performed on March 15, 1955, revealed an incomplete occlusion of the left superficial femoral artery. A fine stream of dye could be seen passing through the partially blocked vessel. The popliteal artery distal to the partial block was considered satisfactory for grafting. On March 24, 1955, a shunt type of homologous arterial graft was inserted without disturbing the superficial femoral or the collateral circulation. The proximal end-to-side anastomosis was placed just distal to the profunda femorus artery take-off. The distal end-to-side anastomosis was placed in the proximal popliteal artery. It should be noted that the femoral artery contained multiple arteriosclerotic plaques and it was difficult to find satisfactory sites for the end-to-side anastomoses. Immediately following operation, a good posterior tibial and a faint dorsalis pedis pulsation could be felt. These have persisted over the follow-up period of the seven months. Anti-coagulant therapy was not used. The primary complaint of intermittent claudication had been completely relieved on this side. He continues to smoke and is now complaining of intermittent claudication on the opposite or right side. In spite of the good result on the left, he refuses further surgery for the right side.

The pre-operative arteriographic findings in this case suggested a pure arteriosclerotic occlusion.

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LONG-TERM SURVIVAL IN CANCER OF BREAST, STOMACH, AND IN MALIGNANT MELANOMAS*

HERBERT FANGER, M.D.

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THE TUMOR CLINIC of the Rhode Island Hospital has been in existence since 1932. It furnishes consultation service for the treatment of patients referred by private physicians of the local medical community. In addition, it is a follow-up clinic for treated ward cases. These cases are of a less favorable type than that seen in the large university medical clinics because these patients usually have far advanced disease when first seen. They are poorly educated, in the lower economic levels, and all too frequently do not recognize the need for medical care until it is too late. They have been treated in several hospitals by surgeons of varying degrees of technical skill and thoroughness. Nevertheless, we have found a considerable number of long-term survivals in patients with malignant neoplasms and are reporting our experiences in cases of breast cancer, stomach cancer and malignant melanoma. We define "long-term survival" as a life span of five years or more, from the time of diagnosis and treatment.

There are 541 cases of breast cancer registered in the tumor clinic for the years 1931-48. Of these, 509 cases can be used. The remaining 32 cases are discarded because of inadequate follow-up. Twenty-seven per cent (146 cases) have survived from 5 to 29 years after diagnosis and treatment. There are 87 cases in the 5-10-year groups, 38 cases in the 10-15-year group, 14 cases in the 15-20-year group and seven cases in the 20-year or more group.

TABLE I

Time	*Cases*	*Living*	*Dead*	*No Follow-up*
5+ Years survival	87	20	49	18
10+ Years survival	38	17	16	5
15+ Years survival	14	5	9	0
20+ Years Survival	7	4	3	0
Totals	146	46	77	23

Now, what happened to the long-term survivors? Seventy-seven of the 146 are dead. Twenty-three are lost to further follow-up study after survival for a number of years. Twelve have died, either due to causes other than cancer, or of unknown causes. This emphasizes the importance of the autopsy in determining the eventual outcome of these cases since death is not necessarily due to the original carcinoma.

We have confirmed the diagnosis in 128 out of 146 cases by review of the microscopic slides. The slides are not available in the remainder, but the pathology report or the case follow-up has enabled us to accept the remaining 18 cases as true cases of cancer of the breast.

In order to determine whether there is a trend for increasing long-term survival after treatment for cancer of the breast, we have reviewed the experiences in groups of five years.

TABLE II

Time	*Cases*	*5+ years survival*	*Per cent*
1932-1935	142	20	14
1936-1940	176	50	28
1941-1945	160	50	31
1946-1948	98	25	25

Table II shows a vast improvement in long-term survival after the first four years of the tumor clinic but in the subsequent 13 years a plateau had been reached.

Twenty-seven per cent long-term survival is not a very high percentage. This is a gross percentage rate since it includes cases with death due to other causes than cancer of the breast. Some of the cases were operated on at other hospitals and then referred to our clinic for terminal care and follow-up. (188 patients were terminal or initially operated at other hospitals; if eliminated, the long-term survival rate is 45 per cent.) It would be interesting to know the over-all experience of cancer of the breast in this hospital, including private patients, as well as tumor clinic patients. This information will become available by the establishment of a hospital cancer registry.

There are reports in the literature that the well-differentiated tumors of the breast tend to have a better prognosis than the undifferentiated tumors. We reviewed the histopathology of our cases of long-term survival and found no constant feature

continued on next page

*Presented at the meeting of the Rhode Island Hospital Research Day, November 10, 1954.

to enable us to differentiate the cases that survived five years from those that survived 15 years. For the most part, the tumors were active, moderately undifferentiated and infiltrating lesions. It is our impression that the majority of breast cancers shows a similar histologic pattern and that this makes it difficult to grade them and use groups of such cases to evaluate prognosis. The exceptions are: intraductal carcinoma, Paget's disease of breast, colloid carcinoma, medullary carcinoma or the highly anaplastic carcinomas. These, however, make up only a small percentage of the tumors.

It is interesting to note that in 69 cases of long-term survival, in which lymph nodes were demonstrated in the axillary dissection, 38 (53 per cent) of them had metastases. In 204 cases of short survivals, in which lymph nodes were demonstrated, 129 (63 per cent) had metastases. This emphasizes the advanced stage of disease in our tumor clinic cases.

The long-term survival in cancer of the breast in young and older women was similar. Twenty-five per cent of the women 23-40 years of age, with cancer of the breast, lived for five or more years. Twenty-eight per cent of women over 40, with cancer of the breast, lived for five or more years. Thus, long-term survival in the younger group was similar to the older. These figures are statistically significant, as shown by use of the chi-square test.

Harrington[1] has reported on 5,548 patients with carcinoma of the breast. He noted that the five-year survival in young women between 20 and 29 years of age was 60.2 per cent, whereas with women in the forties it was 50.2 per cent and in the fifties it was 47.1 per cent. He has reported that there are less patients with cancer of the breast in the earlier decades of life, which may possibly alter the significance of these statistics. Nevertheless, it would seem that the disease does not have a worse prognosis in the younger age groups than in the older. We are excluding the cases of cancer of the breast associated with pregnancy, which has a poor prognosis.

We have no cases of long-term survivals in cancer of the male breast. This bears out the general impression of the poor prognosis of this disease in the male. It has been suggested by Somerville[3] that the prognosis is not as good as in the female because of the rapidity of local and distant spread owing to the limited breast tissue; the tendency for men to ignore the lump; and the occasional failure of the physician to detect early carcinoma and realize its seriousness.

There are only three cases of bilateral breast cancer with long-term survival. It is difficult to determine whether these are cases of metastases from one breast to the other, or whether they are bilateral primary breast cancer. Of the three cases, two had long-time intervals before the appearance of tumor in the opposite breast. This possibly represents a double primary incidence of disease but it is admittedly equivocal.

Harrington[1] has reported a 2.4 per cent incidence of bilateral breast cancer. He had a 35 per cent survival rate for 15 years or more. We have too few cases to be statistically significant, but it should be noted that in the three cases, two lived for six and eight years respectively after the second operation.

In general, it seems fair to say that the long-term survival in bilateral breast cancer is less likely than in unilateral disease. However, the condition is not, invariably, rapidly fatal.

Among the long-term survivors are 11 cases with recurrence. (Table III) These occurred from two to ten years after the original operation and lived one to twelve years after. This emphasizes that five-year survival without recurrence is not a guarantee of cure. Four of our long-term survivors had multiple carcinomas. (Table IV)

TABLE III

Recurrences in Long-Term Survival

		Interval	*Survival After*	*Total Survival Time*
1.	42-5684	3 yrs.	3 yrs.	6 yrs.
2.	44-6494	7 yrs.	1 yr.	8 yrs.
3.	45-6863	5 yrs.	1½ yrs.	6½ yrs.
4.	46-7221	7 yrs.	1 yr.	8 — alive
5.	34-1441	13 yrs.	2 yrs.	15 yrs.
6.	48-8671	10, 13	7 yrs.	20 yrs.
7.	39-420	2 yrs.	4 yrs.	6 yrs.
8.	40-4453	2 yrs.	12 yrs.	12 — alive
9.	41-5206	9 yrs.	6 yrs.	15 yrs.
10.	43-5887	2 yrs.	3 yrs.	5 yrs.
11.	47-7651*	.....	.....	5 — alive

*Date of removal of initial tumor not known.

In summary, we have 146 out of 509 cases of cancer of the breast that have survived for over five years. Breast cancer in the male has a poor prognosis. Breast cancer in young women has no

TABLE IV

Multiple Carcinoma

1.	1931	Adenoca. Rectum	1941	Paget's of Breast (1951 L & W)
2.	1936	Ca. of Breast	1948	Ca. of Stomach
3.	1937	Ca. of Breast	1948	Papillary Cystadenoca. of Ovary
4.	1941	Ca. of Breast	1949	Epidermoid Ca. of Tongue

worse prognosis than in older women. Bilateral breast cancer has a poor prognosis, although not necessarily hopeless.

Stomach

Our tumor clinic has seen 113 cases of cancer of the stomach in the 17-year period 1932-48. Eleven and one-half percent (13) have lived for five or more years. These cases were all treated by sub-total gastrectomy.

Berkson[4] has reported on a statistical study of patients seen at the Mayo Clinic from 1940-49 and revealed that for every 100 patients examined, there were 80 laparotomies and 44 resections with 14 five-year survivals. At the Hines Veterans Hospital from 1931-47, for every 100 patients, there were 63 explorations and 32 resections, with four five-year survivals. The importance of early diagnosis and treatment cannot be over emphasized. Nevertheless, it is difficult to understand why some of our cases have survived for so long with only partial gastrectomy. It should be noted that our long-term survivals include seven cases who are living and well for seven to 14 years after surgery.

Three of the 13 cases died of metastases and one of cerebrovascular arteriosclerosis. Two others died of unknown cause, presumably due to metastases. Seven patients were living and well up to the last visit in the clinic, with three of them lost to follow-up after they had been observed for a number of years after operation.

TABLE V
Stomach

	Survival Time	*Status*
1. 1935	8 years	Dead — ASHD
2. 1935	7	Living — No follow-up since
3. 1939	14	Living & well
4. 1940	13	Dead
5. 1940	14	Living & well
6. 1943	5	Dead
7. 1942	9	Living & well No follow-up since
8. 1941	10	Dead
9. 1943	10	Living & well No follow-up
10. 1945	5	Dead
11. 1946	9	Living & well
12. 1947	7	Dead
13. 1947	7	Living & well

We have reviewed the histopathology of these cases and have confirmed the initial diagnosis of adenocarcinoma in each case. For the most part, these were well-differentiated adenocarcinomas. Four tumors were polypoid; one showed serosal involvement, but in general the longest-term survivors had polypoid or superficial lesions. It goes without saying that early or localized lesions have a better prognosis and at present this is one of the major endeavors in cancer education and treatment.

Lymph nodes were infrequently demonstrated so that one cannot evaluate the relationship between lymph node involvement and ultimate prognosis as evidenced by our long-term survivals.

The rarity of cancer of the stomach in young adults is borne out by our cases. We have only three cases out of 131 which were less than 40 years of age. Our long-term survivors were for the most part in the sixth and seventh decade.

Nine of our long-term survivors are female and four male. There is a general impression that the prognosis of gastric cancer is worse in females than in males. Our figures reveal the opposite to be true. Although they are small in number, they are significant according to the chi-square test.

In summary, we have 13 cases of cancer of the stomach surviving for 5 to 14 years after operation. This is 11.5 per cent of all cases. They were all treated by sub-total gastrectomy. The tumors were for the most part well differentiated. One-quarter of these were polypoid. These cases were in the older age groups.

Malignant Melanoma

We have reported on the cases of malignant melanoma[5] seen in the tumor clinic of the Rhode Island Hospital. Some features are worth-while repeating.

There are 47 cases in the files of the tumor clinic for the years 1932-48; 7 of these cases (14 per cent) have survived for 5 or more years. Many of these cases were terminal, or had an inadequate follow-up which had depressed the percentage of survival. The accompanying chart (Table VI) outlines the significant features of these cases. Five of the 7 cases had metastases which occurred within a year of treatment. These 5 cases have survived from 5 to 12 years, despite the appearance of metastases. To be sure, these are unusual occurrences but they do show that malignant melanomas are not invariably rapidly fatal diseases.

Some of these cases have had multiple skin metastases, as well as regional lymph node metastases, but life has been prolonged after regional lymph node excision, as well as of skin metastases.

In one of our cases, a 57-year-old white woman had a wide excision of a malignant melanoma of the foot. She had local recurrences in the next 2 successive years and these were excised. She was asymptomatic for 6 years until a lymph node metastasis appeared in the groin. This also was excised and she was then asymptomatic for 4 years, when she had a recurrence of tumor in the groin and expired 2 years later. Her total survival time was approximately 14 years. This case demon-

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TABLE VI
Malignant Melanomas

Case No.	Age	Sex	Interval before Metastas.	Survival after Metastas.	Total Period of Survival	Site	Remarks
1. 3996	57	F	11 mo.	10 yr. 10 mo.	11 yr. 8 mo.	Foot	Local excision; recurrences and lymph nodes excised 2, 9, & 12 yrs. later. Survived 14 yrs.
2. 4094	63	F			9 yr. 5 mo.	Foot	Local excision; no recurrences. Died of arteriosclerotic heart disease.
3. 5098	50	F			10 yrs.	Cvx.	Local excision; no metastases. Living and well.
4. 5590	46	M	8 mo.	7 yrs.	7 yr. 8 mo.	Chest	Local excision; multiple recurrences excised in next 2½ yr. Living and well.
5. 5733	25	F	4 mo.	5 yrs.	5 yr. 4 mo.	Foot	Local excision; multiple recurrences removed, but none when last seen in 1948.
6. 5975	52	F	First seen	6 yr. 5 mo.	6 yr. 5 mo.	Foot	Excision of metastatic node. No recurrences when last seen in 1949.
7. 8382	62	F	1 yr.	7 yr. 6 mo.	8 yr. 6 mo.	Foot	Leg amputation 6 yrs. previously for melanoma diagnosed elsewhere. Recurrence in stump.

strates the chronic nature of this disease and emphasizes that one should not take a nihilistic therapeutic viewpoint in the presence of metastases or recurrences.

In general, the degree of anaplasia of the tumor correlates somewhat with the ultimate outcome but it does not permit its use as a reliable prognostic aid.

Our long-term survivals are mostly in the middle-aged group. The majority of the tumors are on an extremity as contrasted, for example, with the face, with its rich blood supply and greater danger for metastases. The lesion on the cervix is unusual and its longevity is contrary to the usual experience.

These tumors were treated by wide local excision, without regional lymph node dissection. In general, lymph node dissection is recommended, but we have five cases who have lived for over 5 years without this procedure. These are obviously exceptional cases, since our figure of 14-per-cent long-term survival is not high.

Discussion

The causes for longevity with cancer are not clear. There are many factors cited by Harrington[1] which must be considered:

1. Adequacy of surgery.
2. Extent of malignant involvement at time of operation.
3. Location of the malignancy.
4. Degree of malignancy as partially shown by microscopic examination of the primary lesion.
5. Presence of other associated conditions such as pregnancy and lactation.
6. General constitutional diseases such as diabetes.
7. Age of the patient.

The most important factor is the extent of disease at the time of operation, as indicated by the presence or absence of regional lymph node metastases.

However, one cannot use this information in order to prognosticate in the individual case. Many of our long-term survivors would have originally been given poor prognoses because of the extent of their disease, general debility and the degree of undifferentiation of the tumor.

This would suggest that there must be other factors that may modify this disease. Some investigators believe that body tissues contain an inherent resistance to malignancy, which may be manifested by inhibiting the extension of the primary growth, as well as its metastases by a connective tissue reaction, such as fibrosis.

It has been suggested that there possibly may be an immunological reaction limiting the spread of disease.

One of the unexplained oddities of malignant tumors is, why they recur years after they have been initially removed and then suddenly grow wildly, spread throughout the body and lead to a rapid demise. One possibility is that there was a small focus of residual tumor, which had lain dormant and then had been stimulated to grow. Possibly this may be produced by hormones. Thus, in the treatment of metastatic or recurrent carcinoma of the breast, estrogens or testosterone, oophorectomy, adrenalectomy, or hypophysectomy have been used in an attempt to alter the steroids of the body and possibly modify the tumor under its influence. Conceivably, the glands of internal secretion may spontaneously influence the tumor, producing periods of growth and regression. This may apply in cancers of the breast and prostate and in malignant melanomas, since these tumors are be-

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THE BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND

Part II

SEEBERT J. GOLDOWSKY, M.D.

(continued from September, 1955, volume XXXVIII, number 9, page 515)

The Author. *Seebert J. Goldowsky, M.D., Surgeon, Miriam Hospital; Assistant Surgeon, Rhode Island Hospital, Providence, R. I.*

AT THIS POINT we shall take a brief look at the college and its surroundings. When the medical school was opened the only buildings on the campus were University Hall and President Messer's barn. The only structure added during the life of the school was Hope College, completed in 1822. "No other street but Angell [wrote a contemporary] then led directly to the river. What is now Waterman Street was chiefly a pasture for horses." The area between Thayer Street and the Seekonk River "consisted of unoccupied meadows and pastures." There was only a scattering of houses in the environs of the college. At the head of College Hill, on the site of the present Van Wickle Hall, the university built in 1810 at a cost of $1452 a brick building to house the grammar school which it had sponsored for many years. This was set aside as an anatomical building upon the opening of the medical school. Dr. C. W. Parsons described it as follows: "Its upper story was used for dissection, and the preparation of specimens for the lectures, and an opening or trapdoor allowed them to be lowered into the lecture-room beneath. The courses on anatomy appear to have been sometimes given . . . probably at an earlier period . . . in the upper rooms of Dr. Bowen's building at the corner of South Main and Leonard Streets. A certain anatomical tradition and aroma lingered around both these classic precincts. I think that most, if not all, the courses in other departments were delivered in University Hall. The audience frequently contained practicing physicians as well as pupils." In Reuben Guild's HISTORY OF BROWN UNIVERSITY (1867) the only reference to the medical school I have discovered has to do with this use of the building: "For many years after the completion of the building, the upper part was used for the Medical Lectures that were formerly given in connection with the College." Most students except those whose homes were in Providence lived at the college and board "never exceeded $1.40" per week.

The organization of the school is clearly described in the following circular issued about 1823 and now preserved in the John Hay Library collections:

"Medical Lectures in Brown University"

"The Medical Lectures in Brown University will commence in the Anatomical Building, in Providence, on the first Thursday in February, and be continued daily for nearly three months.

Theory and Practice of Physic and Obstetrics, by Dr. Wheaton	**$10.00**
Chemistry and Pharmacy, by Professor D'Wolf	**10.00**
Anatomy, Physiology and Surgery, by Dr. Parsons	**15.00**
	$35.00

"The public are informed that no pains have been spared to render the institution worthy of patronage. The Professor of Chemistry has, within the last year, made extensive additions to his apparatus, which render it very complete. A cabinet of minerals has been formed, and collections of specimens are making for teaching the other branches of natural history.

"The Anatomical Museum has recently received very important additions from various parts of Europe, and now contains every preparation, plate and instrument necessary to a teacher of anatomy. Students will be accommodated with separate sets of bones, and allowed ample opportunities in Practical Anatomy.

"A Medical Library is attached to the school, to which the students will be allowed full access.

"The lectures on Surgery will comprise about one fourth part of the course, and nearly every instrument now in use will be exhibited and described. When practicable, students will be allowed to attend surgical operations, and cases of sickness.

"Arrangements are made with the Steward of the College for boarding in the commons at $1.25 per week. Lodging rooms may be hired in the vicinity of the College at a moderate rent, which will make the price of board lower than at almost any Medical School in New England.

"The conditions on which Medical Degrees are conferred are the following:

continued on next page

1st That the candidate sustain a good moral character.

2 That he furnish the Professors with satisfactory evidence of his possessing a competent knowledge of the Latin language and Natural Philosophy.

3 That he shall have attended two full courses of lectures on Anatomy and Surgery, Chemistry and the Theory and Practice of Physic.

4 That he shall have studied three years (including the time of lectures) with physicians of approved reputation.

5 That he shall have submitted to a private examination held by the Professors during the last week of the lectures, or on the Monday and Tuesday preceding Commencement . . . and received their recommendation.

6 That he shall have written a dissertation on some medical subject and read and defended it in the College Chapel before the President, or such college officer as he may appoint, and the Medical Professors and such other professional or literary gentlemen as choose to attend. Where, however, the candidate can offer a satisfactory excuse for being absent at commencement, and has complied with all the other conditions, he will be allowed to send his dissertation, to be read publicly by some other person, all dissertations to be transmitted to one of the Professors at Providence, at least four weeks before Commencement, and read on the Monday and Tuesday preceding that day.

"Gentlemen wishing to become private pupils with Drs. Wheaton and Parsons are informed that they can be accommodated for one, two or three years; that Lectures will be given twice or thrice per week during the year, and that the use of a valuable Library will be allowed, with an extensive collection of Anatomical Preparations; . . . making the advantages for the elementary part of their education equal to those of any private establishment in the country. They have moreover made arrangements with the Professor of Natural Philosophy and the Professor of Botany, by which Medical Students will be allowed to attend their Lectures at the College."

Fig. 3. University Grammar School as it appeared about 1870. Anatomy lectures were held in this building during the active years of the Medical School. ***(Courtesy of the John Hay Library, Brown University)***

In addition to the above there is a well-preserved copy of the catalogue of the school for the year 1822-23 and a photostat of another for the year 1821-22, the original of which is in the Harvard University Library.

University Medical Association

During most of the life of the medical school there existed a Brown University Medical Association organized for the benefit of professors, students and other interested physicians. The constitution, bylaws and minutes in the original manuscript are also in possession of the John Hay Library, clearly written and in a beautiful state of preservation. The preamble to the constitution reads as follows:

"As every attempt to advance science or diffuse knowledge in general, must be esteemed meritorious, by the intelligent and good; as the medical art not only affords an extensive field for the cultivation of the philosophic and inquisitive mind, but is entirely calculated to ameliorate the affections and miseries incident to human life, and administer comfort and ease to mankind, and as literary associations by giving an opportunity, for an interchange of opinion and a resciprocity [*sic*] of sentiments, conduce to an end so desirable and laudable, we the undersigned do agree to form ourselves into an association or literary community under the name and title of the Brown University Medical Association and do, for the regulations and governments thereof unanimously agree to adopt the following constitution . . . ."

The association first met on November 9, 1811, and adopted its constitution two days later. Weekly meetings were held during the academic year. The association conducted a library and at its initial meeting authorized the purchase of books. Interest in this activity was maintained until the end. Medical discussions were typically in the form of debates, participants analyzing the pros and cons of some stated proposition. Typical examples are the first and the very last recorded subjects: "Whether any diseases were produced by absorption" and "In which country France or England has the Medical Science attained the highest degree of eminence." Following its organization the association met regularly until September 4, 1816, on which date it adjourned sine die. No further meetings were held

or recorded for the next seven years. This interval corresponds roughly with the period of relative disorganization extending from the death of Doctor Eddy to the accession of Doctor Parsons. Meetings were resumed on May 9, 1823, at which time an audit of the treasury and an inventory of the library were ordered. They were held regularly until March 28, 1825, on which date the organization appears to have gone out of existence permanently.

Anatomical Study Problems

The problem of procuring specimens for anatomical study presented, as previously noted, continuing difficulties. Wrote Doctor C. W. Parsons: "The whole matter of supply of material for the practical study of anatomy was, as it must be, involved in difficulty and hazard. A full account of it would include tales of nocturnal adventure, the evasion or befooling of night watchmen, and a mysterious traffic." A rather famous or infamous episode concerning this cadaverous materiel has been told and retold in slightly differing versions. According to the account of Doctor C. W. Parsons: "A story is told of a certain skeleton in the course of preparation, which was left in a barrel in front of the 'anatomical building.' . . . By some forgetfulness, it was allowed to remain out-of-doors till college students began to roll and kick it down the steep of College Street, and at the level of Benefit Street it ran against some obstacle, I think the steps of the old town house. Out came the head of the barrel, followed by another head, and great was the consternation and excitement. A startled crowd gathered around the spot; stories were soon astir of desecrated graves; search was even made in one place of a recent burial, which was found not to have been disturbed. A medical student, who was supposed to be implicated, found it convenient to visit his uncle's house in the country, and remained there till the affair had blown over. Dr. Parsons . . . claimed the bones as his own property, but public opinion demanded a prompt and decent burial." It was a matter of tradition in later years that the unpleasant notoriety produced by this unsavory splattering of "armless trunks and trunkless heads" had much to do with attracting public attention to the rumored lack of discipline among the students and the eventual extinction of the school.

Faculty Salaries

The matter of adequate and regular salaries for the faculty was, as we have noted, a course of chronic dissatisfaction. There is in the John Hay Library the original of an interesting letter directed by Doctor Solomon Drowne to the "Honorable Corporation of Brown University" in the year 1824. He addressed himself in this way: "I am not accustomed to speak in my own behalf:—permit

MEDICAL DEPARTMENT

OF

BROWN UNIVERSITY.

FACULTY OF MEDICINE.

ASA MESSER, S. T. D. L. L. D. President of the University.

LEVI WHEATON, M. D. Professor of Theory and Practice of Physic.

WILLIAM INGALLS, M. D. Professor of Anatomy and Surgery.

USHER PARSONS, M. D. Adjunct Professor of Anatomy and Surgery, & Lecturer.

SOLOMON DROWN, M. D. Professor of Botany and Materia Medica.

JOHN D'WOLF, A. M. Professor of Chemistry.

PROVIDENCE, R. I.

December—1822.

B. FIELD, PRINTER.

Fig. 5. Page from catalogue of the Medical Department of Brown University for academic year 1822-23, showing medical faculty for that year. ***(Courtesy of the John Hay Library, Brown University)***

me, then, without further preamble, to enter on the subject of my memorial." Belying this protestation of brevity there followed a long and involved discourse on the beauties and satisfactions of the study of botany and nature. "But to come to the pith of the business [he then continued]:—what I wish is, such a compensation as Professor in the University and curator of our little garden, that I need not be obliged to look to the students for pay,—a troublesome task, attended with lapses. I do not ask for a salary of so high amount as the Professors of Chemistry and Oratory receive,—$500 and $600 respectively though they are my juniors,—for I was one of the very first to introduce actual lecturing in the University,—Professor Nuthall receives $500 annually merely as Curator of the Garden at Cambridge;—a very pleasant business. The mentioning this, however, can avail me but little as our garden is not Cambridge garden,—yet it is the germ and nursery of a botanic garden, that may with patronage increase. It was got up and has been supported hitherto without any expense to the College. I have exercised in it considerably, in introducing plants, useful in Medicine, Rural Economy, and the Arts.—But apart from its utility in these respects, it may be considered as a

continued on next page

Merrill Knowlton

CIRCULAR.

Medical Lectures in Brown University.

THE Medical Lectures in Brown University will commence in the Anatomical Building, in Providence, on the first Thursday in February, and be continued daily for nearly three months.

Theory and Practice of Physic and Obstetrics, by Dr. WHEATON, - - -	$ 10 00
Chemistry and Pharmacy, by Professor D'WOLF, - - - - - - - - - -	10 00
Anatomy, Physiology and Surgery, by Dr. PARSONS, - - - - - - - - -	15 00
	$ 35 00

Fig. 4. Front page of Circular appearing in 1822, announcing Medical Lectures in Brown University. *(Courtesy of the John Hay Library, Brown University)*

leaf of a beautiful volume of nature, in which one may read much of the goodness and wisdom of the Being, whose power is adequate to the production of everything. [signd] Solomon Drowne." Although it is not definitely known whether this letter had any positive influence with the trustees, it is a matter of record that his allowance from fees which had been only $100 in 1823 was raised to $250 in 1825.

Medical Journal Reports

There appeared in Volume II of the BOSTON MEDICAL INTELLIGENCER covering the years 1824 and 1825 a number of references to Brown Medical School and the state of affairs in Rhode Island, of which the discourse by Doctor Waterhouse above referred to appears but to have been a part. An anonymous correspondent wrote: "Its local situation enables us to account for the fact, that the Medical School of Brown University has never had a very great reputation abroad,—for it is between the Massachusetts Medical College on the north, the New York College of Physicians and Surgeons on the south, and the Berkshire Medical Institution on the west, and to these three neighboring schools many of their pupils resort. The course of public lectures in their Medical School is by no means inferior to any in their neighborhood, in point of accuracy or splendor. . . . We had the pleasure of being invited into Professor Parsons' lecture room. . . . His Italian models of anatomy are done in a superior style. . . . [One] could not but admire his unceasing labour to benefit the class, by his anatomical knowledge, as well as practical experience. We had not the satisfaction of listening to the other professors . . . but . . . we learn that their abilities as teachers are uncommonly great."

6

Officers of Instruction.

REV. FRANCIS WAYLAND, JUN. D. D.
President.

*SOLOMON DROWN, M. D. *Professor of Materia Medica and Botany.*

*HON. TRISTAM BURGES, LL. D. *Professor of Oratory and Belles Lettres.*

*LEVI WHEATON, M. D. *Professor of the Theory and Practice of Physic.*

*JOHN D'WOLF, A. M. *Professor of Chemistry.*

*USHER PARSONS, M. D. *Professor of Anatomy and Surgery.*

*HORATIO GATES BOWEN, A. M. *Professor of Natural History, Librarian, and Keeper of the Cabinet.*

WILLIAM G. GODDARD, A. M. *Professor of Moral Philosophy and Metaphysics.*

REV. ROMEO ELTON, A. M. *Professor of Languages.*

REV. ALEXIS CASWELL, A. M. *Professor of Mathematics and Natural Philosophy.*

JOHN WAYLAND, A. B. *Tutor.*

JOHN H. WEEDEN, A. B. *Tutor.*

REGISTER AND STEWARD.
LEMUEL H. ELLIOT.

*The gentlemen to whose names the asterisk is prefixed, are not of the immediate government; and do not, at present, give any instruction in the University. The duties of Professor of Oratory and Belles Lettres, are performed by the President and the Professor of Moral Philosophy—and the duties of Professor of Chemistry, by the Professor of Natural Philosophy.

Fig. 6. Roster of Officers of Instruction in Brown University catalogue for the year 1828-29, showing asterisks before names of medical professors and accompanying footnote as described in text. *(Courtesy of the John Hay Library, Brown University)*

He felt constrained to add, however, "We scarcely recollect a medical publication which has ever emanated from Rhode-Island. The physicians there have neither a periodical journal, nor in fact, leisure to publish, even if they possessed [such] a medium. . . . Surgery, although well managed . . . has never had any very distinguished or able masters. . . . It is said . . . that the celebrated Dr. Miller, of Franklin, Mass., does a third part of the chirurgical business of Rhode Island." Wrote another correspondent: "The plan of the School was, at present, better, but yet it is susceptible of much improvement. I can by an analysis, [which he proceeds to give] give you some idea of this school which, I add, and without ostentation, might, and ought to stand pre-eminent, from the character and talent concentrated in many of its professors, though its number of students will ever be limited . . . from its location in the immediate vicinity of the flourishing schools of Boston and New York." Wrote the editor in comment: "It must be that something is 'rotten in Denmark'. . . ." Following a letter in defense of the school the editor finally published the following note: "We have received several letters alternately praising and blaming the medical school of Brown University; . . . as the complainant . . . keeps his name behind the curtain, we now positively assure him that his communications will receive no further attention unless he is willing to overcome his hesitation in signing his name." Thus came to an end this rather strange correspondence.

Several other items appear in this volume of the Boston Medical Intelligencer which have bearing on the then current activities of the profession in Rhode Island. Among these is the following: "The library of Brown University has received from two young gentlemen alumni, who are now in Europe, a respectable donation of French books, among which are valuable works on Natural History, and on Anatomy and Surgery. The anatomical plates of Cloquet, consisting of 240 engravings of folio size, are executed in a very superior style. These gentlemen have also forwarded valuable additions to the chemical and philosophical apparatus, already belonging to the University."

Farther on we read: "Dr. Usher Parsons, Professor of Surgery in Brown University, has recently established an infirmary, in Providence, for diseases of the eye." Also: "A hospital and quarantine establishment are in contemplation at Providence, R. I., and a lot on Fields Point has been selected and purchased for its location." The problem of hospitals will receive brief attention later.

Medical Library Beginnings

An account of the annual meeting of the Rhode Island Medical Society for 1824 appearing in the same volume is also of interest: "The Society received a letter from Dr. Caleb Fiske, tendering his resignation as a Fellow of the Society, in consequence of ill health, and accompanied by a donation of 72 volumes of valuable books . . . intimating, also, his intention to provide a fund, the annual income of which is intended to excite competition in the investigation of such medical subjects, as the Society may propose for discussion." Dr. Fiske actually lived on another ten years, and the first Fiske prizes were not awarded until 1835. It was noted in the same minutes that Doctors Levi Wheaton and Solomon Drowne were to be appointed orators for the next "anniversary" meeting.

The letter of presentation accompanying Doctor Fiske's gift of medical books is in itself a document of considerable discernment. He wrote: "Believing it to be an object of considerable interest, to establish a Medical Library for the use of the Society, and as no successful effort hath hitherto been made to effect so desirable a purpose, I am induced to commence the work by presenting to the Society seventy-two volumes (including numerous instructive plates). This small beginning may serve as a nucleus for the accretion of useful matter, and it is to be hoped will be followed with additions from time to time by the Society or some of its members. Such an establishment, by furnishing the means of intellectual improvement will probably excite a propensity for medical reading and research, and lead to results honorable to the Society and beneficial to the Community." His hopes of founding a medical library, however, were not then realized. Some years later the following was reported to the Society: "His gift received few, if any additions. The books became obsolete, superseded by more modern works, and were finally donated to the Rhode Island Hospital, in 1868." The Medical Society which was founded in 1812 and of which he became president in 1823, was another and contemporaneous manifestation of the same intellectual ferment which led to the establishment of the medical school. Many of the same personalities were involved in both movements. Amos Throop was the first president of the Rhode Island Medical Society and died in office. An important activity of the Society during these early years, in the face of inadequate regulation and licensure, was the examination and certification by its board of censors of the local practitioners of medicine. Doctor Fiske, himself a pupil of Doctor William Bowen and a successful preceptor in his own right, was granted an honorary M.D. by Brown in 1812.

Medical School Terminated

The medical school came to a rather abrupt end during the years 1827 and 1828 and in a rather odd way. At a special meeting of the corporation held

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on December 13, 1826, the resignation of President Asa Messer, which had been submitted earlier, was accepted and the Reverend Francis Wayland, Jr., of Boston was unanimously selected to be his successor. On the state of the college at this time Reuben Guild wrote: "The circumstances in which he found the College were by no means favorable. . . . The last two or three years of Dr. Messer's administration had been marked by idleness and dissipation on the part of the students. Influences beyond the reach of the President rendered salutary discipline almost impossible, and the results were disastrous alike to the moral and intellectual character of the men under his care." This view of the situation appears to be the conventional one, as Professor Bronson writes: "President Wayland's first work was to tighten the reins of moral and mental discipline which in the last few years had been somewhat relaxed." The tradition persisted, however, as we have already noted, that there was a more than casual relationship between the affair of the barrel of bones and the peculiar severity with which the impending blows were to fall upon the medical school.

Be that as it may, Dr. Wayland "brought with him [stated Dr. C. W. Parsons] very definite views as to college discipline, and a profound conviction of its importance." In pursuance of his objectives he revived and extended an old rule which had required the instructors to visit the students' rooms.

At a special meeting of the Corporation held in March of 1827 the following resolution, in all probability inspired by the President, was adopted:

"*WHEREAS*, it is deemed essential to an efficient course of instruction, and to the administration of discipline in this University, that all its officers be actual residents within the walls of the Colleges; therefore,

"*RESOLVED*, That no salary or other compensation be paid to any Professor, Tutor or other officer, who shall not during the course of each and every term occupy a room in one of the colleges (to be designated by the President), and assiduously devote himself to the preservation of order and the instruction of the students, or the performance of such other duty as may belong to his station."

The secretary was directed to send copies to the non-resident professors. This action was implemented at the next regular meeting in the following manner. Salaries of present and future faculty members were approved only on condition that they "devote themselves during term-time exclusively to the instruction and discipline of this institution, occupy rooms in college during study hours, and attend in their several departments such recitations as the President may direct, not exceeding three recitations of one hour each in every day."

The names of the members of the medical faculty (Doctors Drowne, Wheaton, DeWolf and Parsons) appeared as usual in the University catalogue of 1827-28. The ensuing five years, however, produced a significant series of changes. The catalogue of 1828-29 presented the full medical faculty, but to each of the names was affixed an asterisk with the following explanatory footnote: "The gentlemen to whose names the asterisk is prefixed, are not of the immediate government; and do not, at present, give any instruction in the University." In the following year the same device was used, but in the meantime Dr. Levi Wheaton had eliminated himself. The catalogue for the academic year 1830-31 contained the somewhat more definitive statement: "The gentlemen to whose names the asterisk is prefixed, give no instruction in the University, and have no concern in its government." Doctor Usher Parsons dropped out in 1831-32, leaving only Doctors Drowne and DeWolf. A curious variation can be noted in the catalogue of that year in that the words "for the present" were appended to the footnote. An anonymous hand apparently deeming this phrase too tentative, had struck it out with pen and ink, leaving the final wording unchanged from that of the previous year. By the time the catalogue of 1832-33 appeared the medical faculty had been liquidated quite completely.

Underlying Motives Reviewed

The motives of President Wayland in thus sacrificing the medical school are not now entirely clear. He himself had studied medicine for three years following his graduation from Union College, both with preceptors in Troy, New York, and by attending lectures in New York City. Professor C. W. Parsons was of the opinion that he had no hostile feeling toward the school. The view was expressed in later years (1859) "that the proximity of medical schools in Boston, New Haven and Pittsfield, which were provided with ample accommodations, would always prevent the growth and success of one in Rhode Island and the school was therefore abandoned in 1826 [*sic*]." There is no contemporary document which supports this concept, but it may nevertheless be of some significance as it was written by Doctor Usher Parsons.

The weight of evidence and opinion, however, favors the view that the destruction of this promising institution was in fact merely incidental to otherwise successful and praiseworthy academic reforms. President Wayland himself provided a sturdy example for the moral and intellectual austerity which he sought to impose upon students and faculty alike. He doubtless knew what effect these measures would have upon the medical professors

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NEW ENGLAND AND THE AMA

THE THIRD annual meeting of the American Medical Association was held in Boston in 1849. Three times subsequently, the last in 1921, the scientific session came to Boston, and in the intervening years also met at New Haven (1860) and in Newport, Rhode Island (1889).

As the Association grew in size it found that there were few cities in the nation able to accommodate the number of physicians and their families, and the allied organizations, desirous of participating in the world's greatest medical conclave. As a result it is now thirty-four years since the AMA has come to the Northeast.

The long due visit will be made this year—to Boston on November 29 through December 2. But it will not be Boston's meeting, for the Bay State physicians have graciously waived the privilege of being the single hosts to the doctors of America, and have organized the Interim Clinical Session as a New England presentation. This is fitting, for we are not only a compact region where our states have long since learned to work in close harmony, but more particularly physicians from New England contributed in great measure to the development of the American Medical Association through its 110 years of existence.

New England had two medical schools, Harvard and Dartmouth, long before physicians considered formal organization of their own groups, and the establishment of standards for medical education. The Boston Medical Society had been started about 1735, and New Haven County had an organization, while on the state level Massachusetts, New Hampshire and Connecticut were already chartered medical societies, and in 1848, a year after the start of the AMA, the Rhode Island Medical Society was organized.

When the American Medical Association was formally started Doctor Luther Ticknor, then president of the Medical Society of Connecticut, was one of the prime organizers with Doctor Nathan Smith Davis of Binghamton, New York. Later when the first board of trustees was created it included a Doctor Alonzo Garcelon of Maine who later became president of the trustees when the Association was incorporated. In 1853 Doctor Usher Parsons of Rhode Island was first vice president of the Association.

Through the years New England has had nine of its residents named to the presidency of the AMA, with seven of the physicians claiming Boston as their home, and two, New Haven. The most

continued on next page

recent Bostonian to head this honor to New England was Doctor Roger I. Lee who was the 99th president, serving in 1945.

The third annual session, held in Boston in 1849, saw Doctor John Collins Warren, who three years before in the amphitheater of the Massachusetts General Hospital had done the first public operation under ether anesthesia, nominated as president for the ensuing year. At that meeting standing committees to undertake measurements of progress in each important medical field were established, and preliminary steps taken toward the high standard that was ultimately to prevail in the advancement of American medicine through plans to elevate the standard of medical education.

Sixteen years later the convention again assembled in Boston, and at that session a resolution was adopted to establish norms for the publication of scientific papers that have been instrumental in making the quality of the medical literature of the United States the world's finest.

Rhode Island had the honor of entertaining the American Medical Association at Newport in 1889, and our Doctor Norman MacLeod, health commissioner of that city, still treasures a copy of the interesting program of that occasion, which of course included for the visitors a Rhode Island clambake.

The Newport meeting was marked by many interesting features. Doctor William Pepper gave the address on medicine and devoted it to the life of Benjamin Rush; the Board of Trustees reported that the JOURNAL OF THE AMA had become well established and was a credit to the Association, increasing its page content from 32 to 36 weekly (the average JOURNAL now has 180 pages weekly); a resolution was adopted on the suggestion of the American Social Science Association that a more thorough general education prior to the study of medicine be encouraged; and it was voted to send representatives to the meeting of the U. S. Pharmacopoeia Convention.

The year the first AMA directory of physicians was published, 1906, saw the meeting again at the hub city of the Massachusetts Commonwealth. This was the time the Council on Pharmacy requested that it be supplied a laboratory at the headquarters office; $5,000 was appropriated to the California fund for the benefit of physicians who suffered by the earthquake and fire; for the first time the Council on Medical Education recommended a year of college education before entrance into a medical school; the scientific exhibit completed its seventh showing; and the battle against proprietary medicines assumed strong proportions.

It is interesting to note, and we know not whether there is a family connection, that when the AMA met in Boston in 1921, its last previous visit to this area, the speaker of the House of Delegates was Doctor Dwight Henderson Murray of Syracuse, N. Y., and this December, Doctor Dwight Harrison Murray of Napa, California, will be seated on the rostrum as president-elect of the Association. We will construe this is a very bright omen, for the 1921 Boston session was a lively and successful one.

The Interim Meeting, started several years ago, has not attracted as large an attendance as the annual session held in early June. But the clinical presentations are equally good, the scientific and technical exhibits on a par with those presented at the annual get-together, and the work of the House of Delegates as important as always.

In 1921 the registered attendance at the annual meeting in Boston was 5,506. We are certain that the Interim Clinical Session on November 29-December 2 will far top that figure. The opportunity to hold such an important convention in New England should be welcomed by every physician. Certainly no Rhode Island doctor would appear to have much excuse for not making the 45-mile trip to our neighboring state's capitol sometime during the meeting week.

Welcome to New England, AMA! We are proud to be hosts again to the greatest medical organization the world has ever seen.

HOSPITAL DIRECTORS

We wish to call your attention to the letter in this issue from a prominent psychiatrist discussing some aspects of the recent sad upheaval at Butler Hospital. Of course, what is discussed in this letter goes far beyond one hospital. These matters are attracting a good deal of attention nowadays. At the recent meeting of the New England Surgical Society there was a panel discussion on *Hospital Administration and the Doctor*. This was participated in by two surgeons from two of the biggest, highest grade hospitals in the country, a director or superintendent (we are not sure of his title) of one of these hospitals, and another, not a physician, who is on the board of directors at one of the best-known clinics in the country. These four constituted a remarkable team. It was interesting that the nonmedical member brought up the subject of physicians on the boards of hospital directors and approved of that.

We feel that there is little doubt that the professional staff of hospitals have often been considered merely as technicians on even a higher plane than the most artistic and skillful designers or fabricators in industrial life. We are afraid this impression goes back to the days of the Barber-Surgeons and that it is perhaps more deeply rooted in New England.

There are, however, a great many hospitals in this country that do have physicians on their boards.

There are tremendous problems involved in hospital management in which it would not be reasonable to expect the advice of a physician to be particularly valuable; nevertheless, we feel that the great object for which hospitals are maintained is the medical care, and we do not believe that businessmen, in fact any other type of man, except a physician is well qualified to pass on these problems. Some hospitals which have not allowed physicians to reach this exalted station call attention to the fact that they have combinued committees of the trustees and doctors who take up all the important problems. This sounds well, but the initiative always comes from the trustees and it may well be that in the multiplicity of problems that arise, occasionally the importance of some of them do not impress the trustees sufficiently.

We also have a strong feeling that in these days fashion is playing altogether too great a part in design. We are not sure but that design is sometimes more important nowadays in buildings than it is in women's attire. Although the majority perhaps of new hospitals, which after all have some of the attributes of manufacturing plants, are being built as skyscrapers, we have been interested in riding through the country to find that even now many manufacturing plants are being kept as close to the ground as an up-to-date motel. We think that hospitals should move very slowly in abandoning expensive buildings, undoubtedly better constructed than the new ones, which sad experience tells us are very apt to have a good deal of "Jerry-building" in them.

THE DR. J. E. MOWRY FUND

Members who date back very far in the Providence Medical Association will well remember a tremendous great figure of a man with large, rugged features and a voice as deep and booming as any foghorn, who was accustomed to sitting in the front row at practically all our meetings. When new members came up for election, he would rise to his great height and say, "Mr. President, I move you sir that the by-laws be suspended and the secretary instructed to cast one ballot for the election of these members."

This was Doctor Jesse E. Mowry, who at one time or another held practically all the offices in the Providence Medical Association and the State Society, including the presidency of the Providence Medical Association. In the last part of his active career with us he was treasurer of the State Society and he was indeed a watchdog of the treasury. Few men have rendered such service to the medical profession in this state as did Doctor Mowry.

He was a general practitioner. As far as we know he was not connected with the staff of any of our hospitals, but throughout his career he maintained a familiarity with all the advances in medicine. No man was ever more respected or admired by a large group of patients. When he died on May 3, 1952, he left a widow who had to be kept in one of our institutions. This necessitated, of course, a large expense and he provided that the expense should be met from his estate, and that when the widow died a certain portion of the residue should come to the Rhode Island Medical Society. We are pleased to state that we have just received the goodly sum of $6,131.54. Doctor Mowry appreciated how awkward it sometimes was to have too many restrictions on such a bequest; he did not intend that this should happen as far as he was concerned, and he left this entire sum to be invested and income to be used for our current expenses.

We have never had anybody just like Doctor Mowry, but we wish we had.

THE GREAT FLOOD

About a dozen years ago, the City of Hartford, fearing that their big industrial plants might be bombed, organized a defense program. The man responsible for the medical end of this was the late Doctor Donald Wells. The bombers never came over, but the big top of the Ringling Brothers Circus caught on fire. Many people died and even more people were severely burned. The defense organization rose to the occasion and the story they had to tell us when we went down to the Hartford Hospital to see how things were handled was truly an inspiring one. Now in Rhode Island Governor Roberts has had organized a civil defense program, and under the leadership of the late General Murphy, and since his death, of Colonel, now General McGreevy, a most elaborate system of preparations has been put into effect.

continued on next page

RE BUTLER HOSPITAL EDITORIAL

September 15, 1955

Editor-in-Chief
Rhode Island Medical Journal:

The editorial which appeared in the last issue of the RHODE ISLAND MEDICAL JOURNAL regarding Butler Hospital was excellent. I greatly appreciated reading it, and feel that it represented correctly the situation as it exists.

I was particularly interested in your remarks regarding the broader base for a Board of Directors. I think this is a very good suggestion, and if followed out we would still have the hospital.

Your reference to the present facility is also very good, as certainly institutions are made up of people, and not buildings.

I wanted you to know that I very much enjoyed this article, and hence this letter.

Sincerely yours,

FULLER MEMORIAL SANITARIUM
LAURENCE A. SENSEMAN, M.D.
Medical Director

Once again we looked for bombers, but we got water from the skies. All the elaborate preparations paid off by what has been accomplished for relief in the northern part of our state. We have before us a report of the welfare services in the Woonsocket Flood written by Mr. Edward F. McGrath, Co-ordinator of Emergency Welfare. Under the leadership of General McGreevy, Mr. McGrath has been living at the scene of disaster. Previous experience let us know that he would be on the job working not only tirelessly, but also efficiently.

The story starts at 9:30 A.M., August 19, 1955, when General McGreevy and Mr. McGrath went to Woonsocket and were joined by Mayor Coleman and Chief of Police Edgar C. Turcotte. At that time there was a great deal of damage already done, but they were able to look it over and size up the situation; within a few hours it was evident that those who wished to survive would have to leave the low areas and take to the heights. Evidently there was lots of willing help from the doctors, nurses, Red Cross, the Salvation Army and even the local restaurants. One interesting item was: "One Clergyman provided Clam Chowder and Fish and Chips for Auxiliary Policemen."

One of the incongruous features of such floods as these is that there is a lack of drinking water. Mains are ruptured and have to be shut off, if possible, and certainly the flooding waters are not fit to drink. The primitive conditions that such a disaster produces is emphasized by the fact that the drinking water had to be brought in by tanks provided by the National Guard and the Narragansett Racing Association. Mr. Reidy's Department of Social Welfare had to man shelters for twenty-four hours a day for seven days to assist the Red Cross.

The medical work necessary was under the direction of Doctor Deery and his staff of nurses, and at the last reports which we had they were still right there. One happy observation which we can make right here is that the efficient handling of all these terrific problems makes the task of the medical profession easier. We have heard no suggestion that typhoid, dysentery, or the other infections associated in past years with catastrophes, have been at all prominent at this time. However, only eternal vigilance on the part of the Health Department will prevent serious medical dangers rising. We may well be proud of the way in which this disaster has been handled by General McGreevy, Mr. McGrath and all their willing assistants.

LONG-TERM SURVIVAL IN CANCER OF BREAST, STOMACH, AND IN MALIGNANT MELANOMAS

concluded from page 554

lieved to be under hormonal (steroid) influence.

The statistics cited should serve as a base line of prognosis based on experience in the local medical community. The figures are for a group of the more unfavorable cases. Nevertheless, they show that even in these cases, cancer is not invariably fatal. It should be emphasized that cancer is a chronic disease. Thus, in Daland's[2] analysis of 100 consecutively untreated patients with breast cancer, 22 per cent were alive at the end of five years and nine per cent at the end of seven years. Although cancer is frequently a cause of death, it may not occur for many years. The doctor should keep this in mind when offering a prognosis about tumor to a patient or family.

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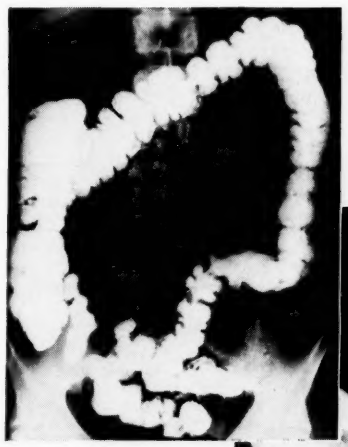
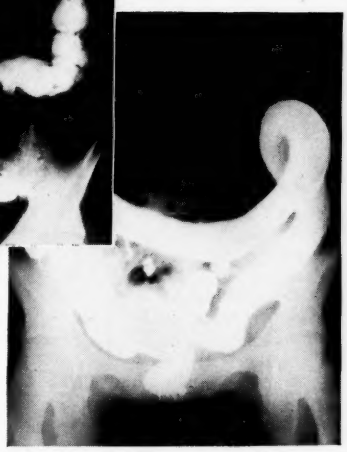
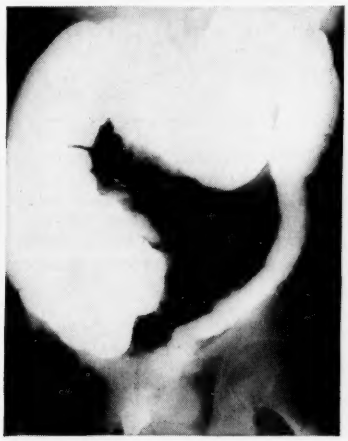


Normal Colon



Ulcerative Colitis



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SEARLE

ROSTER OF FELLOWS 1955
THE RHODE ISLAND MEDICAL SOCIETY
October 1, 1955

Where District Society is not listed after the name the Fellow is a member of the Providence Medical Association.

Telephone numbers have been checked with the latest available directories and every effort has been made to insure accuracy.

Any errors in this listing should be reported immediately to the Executive Office of the Society.

***Indicates non-resident member.**

KEY TO SPECIALTIES

A—Allergy
ALR—Otology, Laryngology, Rhinology
Anes—Anesthesiology
Bact—Bacteriology
C—Cardiovascular Disease
CP—Clinical Pathology
D—Dermatology
G—Gynecology
GE—Gastroenterology
Ger—Geriatrics
HAd—Hospital Administration
I—Internal Medicine
Ind—Industrial Practice
N—Neurology
NS—Neurological Surgery
OALR—Ophthalmology, Otology, Laryngology, Rhinology
Ob—Obstetrics
ObG—Obstetrics, Gynecology
Oph—Ophthalmology
Or—Orthopedic Surgery
P—Psychiatry
Path—Pathology
Pd—Pediatrics
PH—Public Health
PL—Plastic Surgery
PM—Physical Medicine
PN—Psychiatry, Neurology
Pr—Proctology
Prev. Med—Preventive Medicine
Pul—Pulmonary Diseases
R—Roentgenology, Radiology
S—Surgery
U—Urology

Information compiled from the American Medical Association Directory, the Directory of Medical Specialists and the Yearbook of the American College of Surgeons.

The name of a physician who *limits his practice* to one field is marked with the appropriate symbol.

A

Abbate, Rocco (*Kent*) 873 Warwick Avenue, Lakewood (I) ..... HO 1-3323
Abramson, Lewis, (*Newport*) 280 Broadway, Newport (Pd) ..... Newport 5400
Addario, Carmelo, (*Washington*) Box 323, North Road, Shannock ..... Carolina 4-7213
Addonizio, Ercole A., 928 Manton Avenue, Providence ..... EL 1-8112
Adelman, Maurice, 209 Angell Street, Providence 6 (Pd) ..... DE 1-9129
Adelson, Samuel, (*Newport*) 135 Touro Street, Newport (S) ..... Newport 784
Agnelli, Freeman B., (*Washington*) 29 Elm Street, Westerly (PH) ..... Westerly 2507
Allen, Reginald A., 289 Angell Street, Providence 6 (Pd) ..... GA 1-5552
Allin, Francis E., 11 George Street, North Providence ..... CE 1-6411
Anderson, Carl V., (*Kent*) 584 Cowessett Road, Warwick (S) ..... TU 4-4262
Angelone, C. Thomas, 872 Park Avenue, Cranston 10 ..... HO 1-3900
Angeloni, Tito, 151 Jastram Street, Providence
Appleton, Ruth, 41 Taber Avenue, Providence 6 (Pd) ..... GA 1-4033
Archetto, Angelo, 964 Cranston Street, Cranston (Anes) ..... EL 1-3717
Arciero, Michael, 225 Admiral Street, Providence 8 ..... GA 1-7330
Arlen, Richard S., 359 Broad Street, Providence 7 ..... DE 1-8210
Armington, Herbert H., 789 Broad Street, Providence 7 ..... ST 1-4115
Ashton, George W., (*Woonsocket*) Chapel Street, Harrisville ..... Pascoag 91
Ashworth, Charles J., 184 Angell Street, Providence 6 (S) ..... GA 1-4370
*Astle, Christopher J., 1232 East 27th Place, Tulsa, Oklahoma (Oph)
Ayala, Alfredo, Capt., MC (*Kent*) U. S. Army Hospital, 8454th DU, Sandia Base, Albuquerque, New Mexico

B

Babcock, Henry H., 71 Rutledge Road, Belmont, Massachusetts (P)
Badway, Joseph M., 549 Broadway, Providence 9 ..... UN 1-3947
Baldridge, Robert R., 192 Angell Street, Providence 6 (S) ..... GA 1-3448
*Bandeian, Alice M., (*Pawtucket*) 210 Pine Street, Holyoke, Massachusetts ..... Holyoke 2-3254
Barber, Paul E., (*Kent*) 1022 Main Street, West Warwick ..... VA 1-8400
Barnes, Albert E., (*Pawtucket*) 491 Broad Street, Lonsdale ..... PA 5-1740

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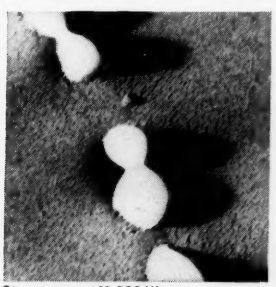
The organisms commonly involved in

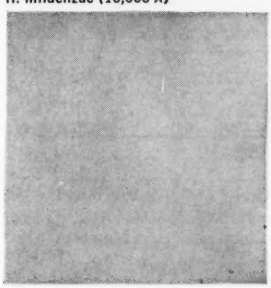
Croup (pharyngolaryngitis)

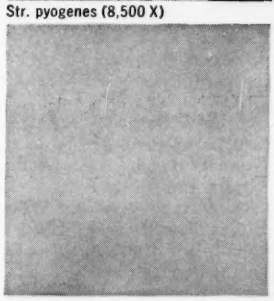


H. influenzae (16,000 X)

Str. pyogenes (8,500 X)

C. diphtheriae (6,000 X)





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Barrett, John T., 122 Waterman Street, Providence 6 (Pd) ..... JA 1-2244
Barrett, Joseph T., (*Kent*) 2317 West Shore Road, Warwick (Pd) ..... RE 7-0098
*Barry, Ambrose G., (*Pawtucket*) Veterans Administration Hospital, Sunmount, New York
Bartley, James H., Jr., 7 Benefit Street, Providence 3 ..... DE 1-6350
Basilevich, Ivan, State Hospital for Mental Diseases, Howard (Ger) ..... HO 3-8100
Batchelder, Philip, 129 Waterman Street, Providence 6 (R) ..... GA 1-2166
Bates, Reuben C., 122 Waterman Street, Providence 6 (Pd) ..... GA 1-4233
Baute, Joseph A., (*Kent*) 4547 Post Road, Warwick ..... TU 4-9440
Beardsley, J. Murray, 154 Waterman Street, Providence 6 (S) ..... UN 1-1880
Beaudin, Briand N., (*Kent*) 46 West Warwick Avenue, West Warwick (Pd) ..... VA 1-3650
Beaudoin, Louis I., (*Pawtucket*) 796 Central Avenue, Pawtucket ..... PA 2-7696
Beaudreault, Elphege A., (*Woonsocket*) 441 South Main St., Woonsocket (S) ..... Woon. 4949
Beck, Irving A., 355 Thayer Street, Providence 6 (I) ..... UN 1-1452
Beckett, Francis H., 189 Waterman Street, Providence 6 ..... GA 1-3342
Behrendt, Vera M., State Hospital, Howard (P) ..... HO 3-8100
Bell, Duncan W. J., 227 Angell Street, Providence 6 (Pd) ..... DE 1-0159
Bellano, George W., 315 Plainfield Street, Providence ..... EL 1-4910
Bellavance, Cyril J., 167 Angell Street, Providence 6 (Or) ..... DE 1-4901
Bellin, Leonard B., 325 Angell Street, Providence 6 (Pd) ..... DE 1-3455
Bellino, Antonio E., 341 Broadway, Providence 9 ..... PL 1-2224
Benjamin, Emanuel W., 105 Waterman Street, Providence 6 (R) ..... JA 1-1441
Bernardo, John R., (*Bristol*) 342 High Street, Bristol (ObG) ..... CL 3-8874
Bernasconi, Ezio J., 726 Broad Street, Providence 7 (Oph) ..... WI 1-3212
Bernstein, Perry, 169 Angell Street, Providence 6 (ObG) ..... DE 1-5115
Berrillo, Anacleto, 409 Broadway, Providence 9 ..... UN 1-6611
Bertini, Armando A., (*Pawtucket*) 9 Cottage Street, Pawtucket ..... PA 5-7329
Bertone, Virgilio M., (*Woonsocket*) 21 Hamlet Avenue, Woonsocket ..... Woonsocket 2560
Bestoso, Robert L., (*Newport*) 64 Touro Street, Newport ..... Newport 3036
Billings, Edmund, 223 Thayer Street, Providence 6 (S) ..... DE 1-6085
Bird, Clarence E., 82 Waterman Street, Providence 6 ..... GA 1-1009
Bishop, E. Wade, 182 Waterman Street, Providence 6 ..... GA 1-2475
Blackmore, Paul A., 141 Waterman Street, Providence 6 ..... GA 1-7487
Blanchard, Howard E., 59 Elmwood Avenue, Providence 7 (ALR) (PL-ALR) ..... GA 1-2622
Bliss, Joseph A., (*Woonsocket*) 15 Monument Square, Woonsocket ..... Woonsocket 3434-W
Blount, Samuel G., 7 French Road, Box 127, Kingston ..... Narragansett 3-2447
Bolotow, Nathan A., 126 Waterman Street, Providence 6 (ALR) (PL-ALR) ..... GA 1-5387
Botvin, Morris, 155 Angell Street, Providence 6 (Oph) ..... UN 1-1210
Boucher, Paul E., (*Woonsocket*) 55 Hamlet Avenue, Woonsocket ..... Woonsocket 67-W
Boucher, Reginald H., (*Pawtucket*) 704 Main Street, Pawtucket ..... PA 3-5534
Bourn, Lucy E., 456 Brook Street, Providence 6 (Pd) ..... DE 1-1694
Bowen, Earl A., 669 Park Avenue, Cranston 10 ..... HO 1-4130
Bowen, J. Robert, 205 Waterman Street, Providence 6 (S) ..... JA 1-0500
Bowles, George E., 154 Waterman Street, Providence 6 (ObG) ..... DE 1-1898
Boyd, James F., 195 Angell Street, Providence 6 (R) ..... GA 1-1589
Bradshaw, Arthur B., 49 Beacon Avenue, Providence 3 ..... GA 1-3852
Bray, Russell S., 454 Angell Street, Providence 6 (GE) ..... PL 1-2440
Brennen, Earle H., 58 John Street, East Providence 14 ..... EA 1-0942
Breslin, Kate, 48 Dartmouth Avenue, Warwick ..... WI 1-1519
Breslin, Robert H., 1494 Broad Street, Providence 5 ..... HO 1-3113
Brochu, Charles E., (*Woonsocket*) 38 Hamlet Avenue, Woonsocket (R) ..... Woonsocket 6174
Brothers, John H., 637 Smith Street, Providence 8 (I) ..... DE 1-4180
Brownell, Henry W., (*Newport*) 278 Broadway, Newport ..... Newport 512-W
Bruno, C. Paul, (*Bristol*) 51 Church Street, Bristol ..... CL 3-8444
Bruno, Louis C., 915 Smith Street, Providence (ObG) ..... DE 1-3722
Bruno, Rocco, (*Pawtucket*) 193 East Avenue, Pawtucket ..... PA 3-4669
Bryan, Charles E., 425 Willett Avenue, Riverside 15 ..... EA 1-0961
Buffum, William P., 122 Waterman Street, Providence 6 (A) ..... GA 1-3446
Burgess, Alex M., 107 Bowen Street, Providence (I) ..... DE 1-8454
Burgess, Alexander M., Jr., 454 Angell Street, Providence 6 (I) ..... PL 1-2440
Burns, Francis L., 382 Broad Street, Providence 7 (ALR) ..... DE 1-1164
Burns, Frederic J., 5 Hillside Avenue, Providence 6 (I) ..... JA 1-7316
Burns, Louis E., (*Newport*) 24 Bull Street, Newport ..... Newport 39
Burrows, Ernest A., 116 Waterman Street, Providence 6 (PN) ..... GA 1-3636
Burton, Kenneth G., 124 Waterman Street, Providence 6 (Or) ..... GA 1-0473
Butler, Edward J., Jr., (*Pawtucket*) 387 Broadway, Pawtucket ..... PA 3-5780
Butler, William J., 227 Angell Street, Providence 6 (R) ..... DE 1-1110
Buxton, Bertram H., Jr., 167 Angell Street, Providence 6 (ObG) ..... GA 1-6431

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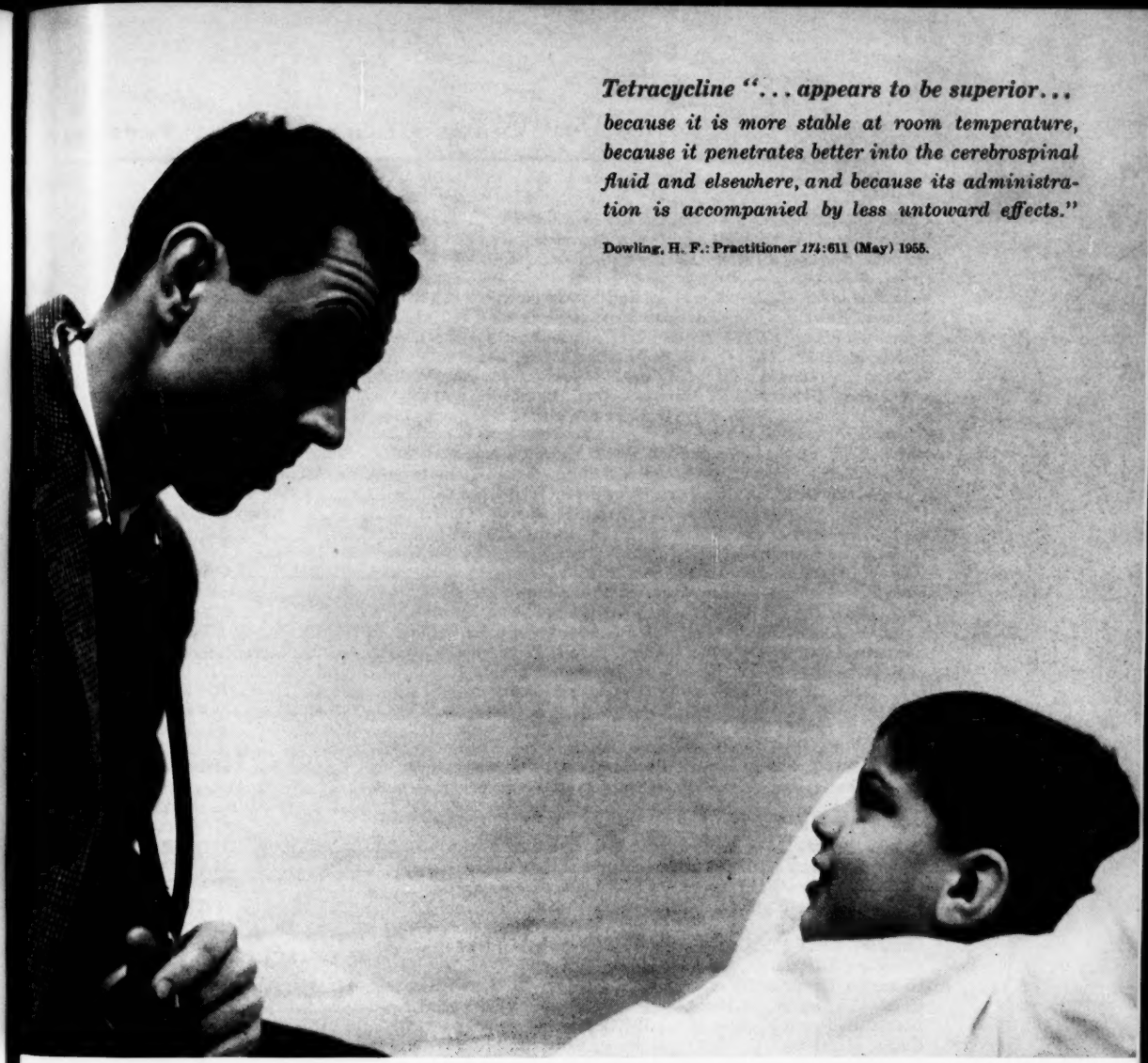

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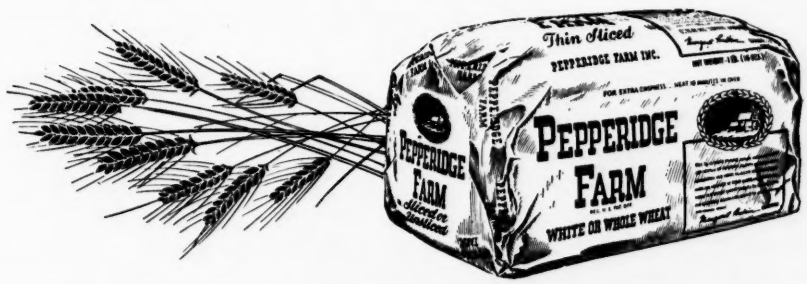

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SEGMENTAL ARTERIAL OCCLUSIONS TREATED WITH RESECTION AND GRAFTING

continued from page 550

However, at operation, the process was found to be generalized. The shunt type of graft proved to be satisfactory in this instance even though the distal anastomosis was to the popliteal artery. Nabseth[9] states that in a series of six cases where shunt grafts were used and a distal anastomosis occurred at the popliteal artery, there have been five failures. One of the failures was due to infection and four due to thrombosis of the shunt graft. He believes that the thrombosis occurs because of an inadequate popliteal channel.

The following two cases represent emergency situations, but are included here because homologous arterial grafts were employed.

Case IX. F.C. A seventy-six-year-old alcoholic who is said to have been lying on a doorstep for two days prior to admission. On examination, there was complete paralysis and coldness of both lower extremities to the level of the groins. He was explored immediately for a saddle embolism. However, at operation, he was found to have a thrombotic occlusion of the distal aorta and iliac vessels. The distal aorta and iliac vessels were resected and a bifurcation homologous aortic graft implanted. The patient went into shock four hours postoperatively and expired eight hours later.

Case X. K.W. A thirty-seven-year-old white male truck driver fell asleep at the wheel at midnight on April 23, 1955. He was thrown clear of the truck and was admitted to an out-of-town hospital at 2:10 A.M. Because he was in shock and there was concern about intra-abdominal injuries, it was not noted until 6:00 A.M. that the left arm was cyanotic, pulseless and flaccid. Nine hours after the injury, another surgeon in this hospital explored the left subclavian and brachial vessels and found them to be divided and completely occluded with fresh clot. All three brachial plexes cords were also completely severed. The brachial vein was ligated and a portion of the contused subclavian and axillary artery was resected and replaced with an autogenous saphenous vein graft. This graft was seen to be non-functioning at the end of the operative procedure, and there was no improvement in the left arm. Re-operation was begun at approximately 8:00 P.M. The sub-clavian artery was found to be contused and thrombosed proximal to the vein graft. Re-resection was carried out and a homologous arterial graft inserted. The final anastomosis was accomplished approximately twenty-four hours from the time of injury. A retrograde flush using heparin solution was carried out through the radial artery at the wrist prior to completing the distal anastomosis. On releasing the clamps, blood was seen to appear in the wrist

wound. However, gangrene of the left hand occurred and demarcation occurred at the level of the left forearm. At mid-humeral amputation, the muscles were found to be necrotic.

In view of the complete severance of all three brachial plexes cords, the salvage in this case would probably have been a flail arm. It was felt that if circulation could have been restored, it might have been possible later to accomplish nerve reconstruction. However, prolonged ischemia had resulted in muscle necrosis by the time the arterial graft was functioning.

Results

The follow-up period of observation on this series of cases varies from two to eight months and is far too short for long-term evaluation of arterial grafting procedures in the patient with generalized arteriosclerosis. Evaluation of the results in this group has been based largely on clinical factors:

1. Restoration and persistence of pedal pulses.
2. Healing of gangrene and trophic ulcers.
3. Relief of intermittent claudication.
4. General symptomatic improvement.

Those patients who obtained satisfactory results from grafting and were facing amputation prior to operation satisfied these criteria. Post-operative angiograms were considered hazardous in this group of patients and therefore have been avoided where a good clinical result had been obtained. Grading of results has not been necessary and as can be seen in Table III, a good result has meant preservation of the already doomed extremity. Failure in each instance has resulted in loss of limb.

TABLE III

Overall Results of Arterial Grafting

No. of Grafts	Good Result	Failure
10	6	4

Three of the four failures occurred in emergency situations which were accepted for surgery as almost hopeless (Cases VI, IX, and X). The fourth failure can be considered avoidable since it resulted from infection and resulting distal thrombosis (Case III).

In Table IV, the results of various vessels treated are compared.

TABLE IV

Comparison of Location

	Clinical Results	
	Good	Bad
Aorta		1
Common Iliac	1	
External Iliac		1
Superficial Femoral	4	1
Femoral to Popliteal	1	
Subclavian		1

concluded on page 579

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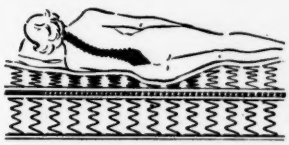
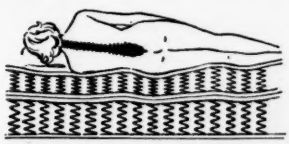


With bed board added, mattress still sags, spine is still distorted.



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concluded from page 577

SUMMARY AND CONCLUSIONS

An attempt has been made to evaluate the results of arterial grafting procedures in a small number of generalized arteriosclerotic patients exhibiting discrete segmental occlusions. Since these patients were already facing amputation because of trophic changes such as ulcers, gangrene, and rest pain, it is felt that this group represents the most difficult problem to deal with. The only prerequisite was angiographic evidence of a patent popliteal artery distal to the segmental occlusion. During a follow-up period of observation from two to eight months and ten operative procedures, good results have been obtained in six of the cases or 60%. Where the operation resulted in failure, amputation occurred in each instance. Since these limbs were already doomed to amputation, it would seem that the risk involved was worth while. Sepsis occurring at the graft site is a definite hazard and resulted in one of the failures. The results of resection and grafting for acute thrombotic occlusion has been universally bad in this series. Although this series is small, it would now appear that resection and grafting procedures may prove helpful in carefully selected cases of diffuse arteriosclerosis when there is impending gangrene.

Selection depends on arteriographic evidence of a patent artery distal to the occlusion suitable for anastomosis.

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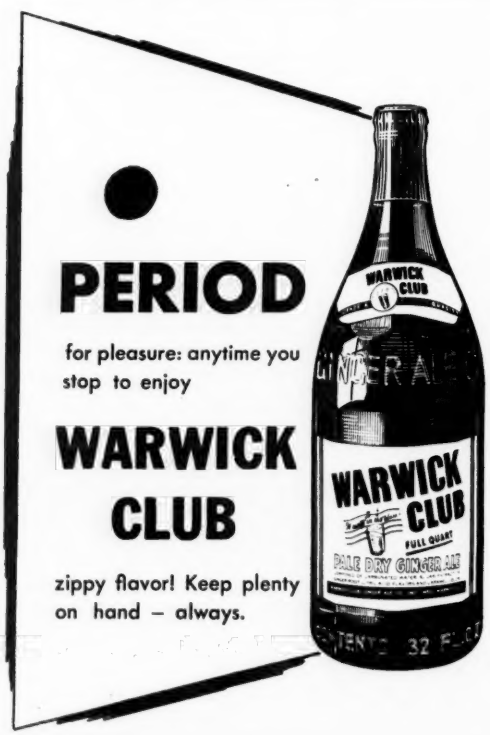

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BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND – PART II

continued from page 560

and apparently was ready to accept the inevitable in the face of what he considered the greater good of the college. At any rate it soon became clear that men in active practice, poorly paid by the college and dependent for a livelihood on their physicians' fees, could not long continue. As it came to the attention of the community that a number of eminent professors had been released, there ensued a running controversy in the local press. Most of the feeling, however, seems to have been engendered by the dismissal of Tristam Burges from the chair of Oratory and Belles-lettres. U. S. Representative from Rhode Island, he was a prominent lawyer, orator, politician, and a very popular figure locally. He was nevertheless subject to the same code as the others and suffered the same fate. An editorial of 1830, however, stated that: "Some of the most able professors that formerly graced this institution have been dismissed, almost with insult, and nearly the entire course of lectures in different branches of science, which alone formed any pretense for denominating the institution a University, have been dispensed with, without an effort on the part of the Corporation to preserve these advantages to the students." Professor C. W. Parsons weighed the gains in closer teacher-pupil relationship and in moral and mental development against the advantages of welcoming "men of distinction and power . . . engaged in . . . active pursuits outside the college, who bring with them a breath from the conflicts of mature life." He concluded: "In drawing the reins up so suddenly and turning so sharp a corner, it was not strange that something should be jolted out, and the medical school had the loosest hold." Professor Waite comments somewhat obliquely: "This may be considered the first attempt to install full-time medical teachers."

Medical School Contributions

During its brief history the medical school made a not inconsiderable contribution to medical education. No complete roster of the students is now available, but the number in attendance appears to have fluctuated between twenty-five and fifty. There is slight variation in the number of graduates attributed to the school, but C. W. Parsons who lists them by name identifies eighty-eight. Of these, twenty had previously received an A.B. from Brown or some other college. In addition between 1804 and 1828 thirty-one honorary M.D. degrees were awarded.

A list of those receiving honorary M.D.'s reads like a medical "Who's Who" of the period, including such names as Solomon Drowne, Pardon Bowen, Levi Wheaton, William Corlis Bowen, William Ingalls, John Mackie, John Mathewson Eddy, William Blanding, Caleb Fiske, David King (the leading physician of Newport) and Usher Parsons. Among the graduates in course a number became prominent members of the profession locally. Lewis L. Miller, Class of 1820, who practiced in Providence for forty years, became an eminent surgeon and served as president of the Rhode Island Medical Society in 1846-47. George Capron, Class of 1823, who practiced for fifty years, was [according to his obituary] "physician to the United States Marine Hospital in Providence" and president of the Rhode Island Medical Society in 1850-51. He contributed a number of papers to the medical literature. Francis L. Wheaton, Class of 1826, was commissioned surgeon-general of Rhode Island during the Mexican War and served as a surgeon in the armed forces throughout the Civil War. Hiram Allen, Class of 1825, who practiced in Woonsocket, became president of the Rhode Island Medical Society in 1851-52. Most of the other graduates became useful members of the profession.

A few attained prominence beyond the confines of the state. Doctor Jerome V. C. Smith, Class of 1818, served as port physician of Boston for twenty-three years, taught at Berkshire Medical College, contributed numerously to the medical literature and edited the BOSTON MEDICAL AND SURGICAL JOURNAL for twenty-eight years. He was elected mayor of Boston in 1854. Doctor Alden March, Class of 1820, founded Albany Medical College where he served as president and professor of surgery. He became a distinguished surgeon in Albany and was recognized nationally by his election to the presidency of the American Medical Association.

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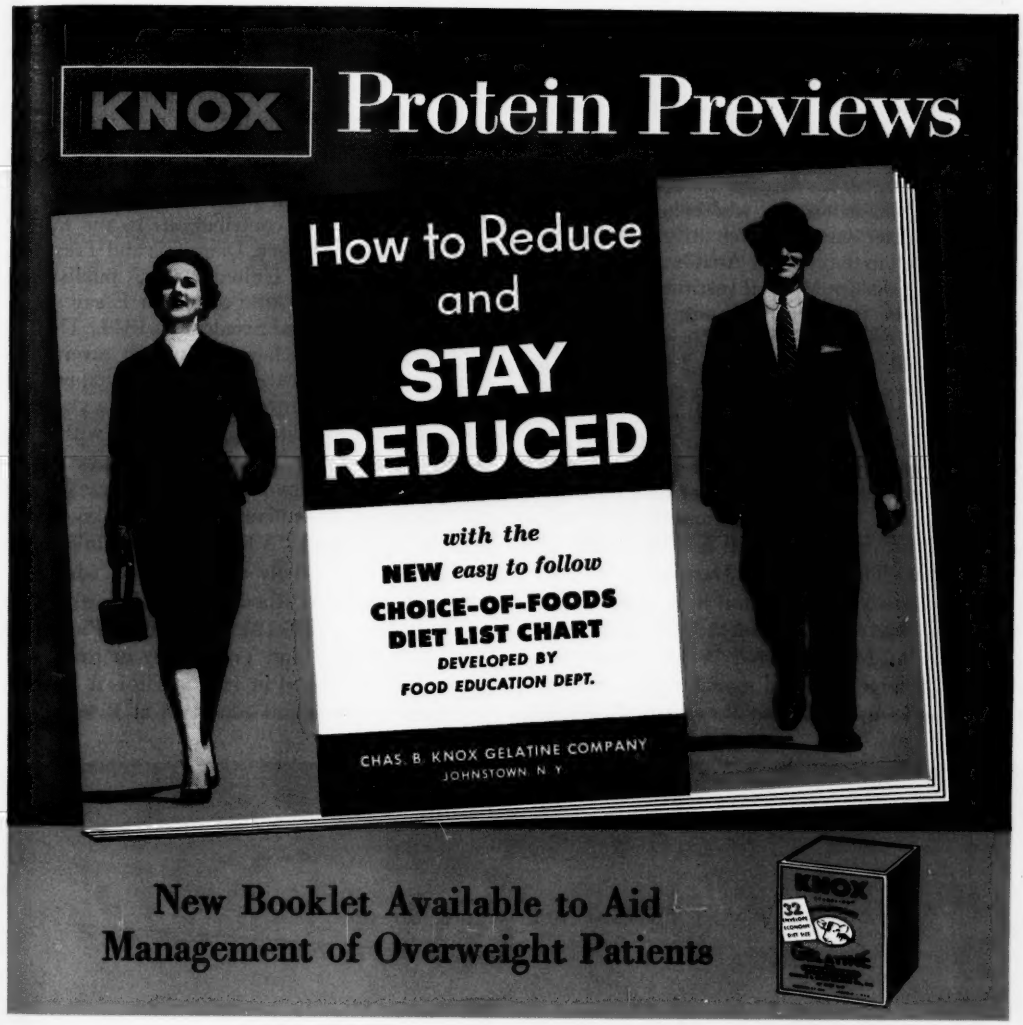

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BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND – PART II

continued from page 590

The most distinguished of all was Dr. Elisha Bartlett, graduate of the Class of 1826, the last under the administration of President Asa Messer. After a year of study in Paris, which had a considerable influence on his medical thinking, he settled in Lowell, Massachusetts, where he was elected mayor and later state representative. In 1832 he was appointed to the chair of Anatomy and Materia Medica at Berkshire Medical Institute at Pittsfield, Massachusetts, fulfilling his ambition to enter the teaching profession. He held this appointment for eight sessions. "For many years," wrote William Osler, "there was in this country a group of peripatetic teachers who like the Sophists of Greece, went from town to town, staying a year or two in each, or they divided their time between a winter session in a large city school and a summer term in a small country one." Associating himself with these wandering professors, Bartlett taught in a total of nine schools. These included Dartmouth, Transylvania University at Lexington in Kentucky, University of Maryland, Vermont Medical College, University of Louisville and Woodstock in Vermont. His career reached its culmination in 1852 when he was appointed to the chair of Materia Medica and Medical Jurisprudence at the College of Physicians and Surgeons in New York. He resigned after only two years because of ill health, having been affected by an obscure neurological disorder. He retired to his native Smithfield, Rhode Island, where in 1855 he died an untimely death in the fifty-second year of his life. He was a popular and magnetic lecturer and gifted as a public speaker, essayist and poet. His lasting fame rests mainly on two contributions to the medical literature: "The History, Diagnosis and Treatment of the Fevers of the United States," published in 1842 under a longer title and "An Essay on the Philosophy of Medical Science" in 1844. The first mentioned work which went through several editions gave the first clear-cut differentiation between typhus and typhoid fevers. The latter, a classic of American medical literature, defined with great clarity the basis for a rational and scientific approach in medical investigation. He was himself the subject of a brilliant biographical sketch by William Osler titled, "A Rhode Island Philosopher, Elisha Bartlett," briefly quoted above, which was first read before the Rhode Island Medical Society on December 7, 1899. Wrote Donald Fleming in his essay "Science and Technology in Providence 1760-1914" published in 1952: "He is a sufficient justification of medical education at Brown."

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Although the activities of the Medical School came to an end in 1827 there remained some unfinished business. On September 5th of that year the following letter was addressed "To the Fellows of Brown University":

Gentlemen,

William S. Stanley, Elihu White & Francis L. Wheaton, having fulfilled the requisite conditions as Medical Students—we, after due examination & inquiry beg leave to recommend them as candidates for the degree of Doctor of Medicine.

respectfully

Solomon Drowne
Levi Wheaton

Providence Sept. 5, 1827

This courteous request appears to have gone unheeded, as a year went by without any action being taken. Then followed this somewhat sharper communication:

To the President & Fellows
of Brown University

Gentlemen,

Permit us to recommend as candidates for the degree of Doctor of Medicine William S. Stanley, Elihu White, & Francis L. Wheaton—they having complied with the rules & regulations hitherto required at this University—with the expectation of receiving that honour to which we think them entitled.

respectfully

Solomon Drowne
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The result in this instance apparently was satisfactory, thus bringing to an end a brief but eventful era.

(to be continued)

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BOOK REVIEWS

CLINICAL BIOCHEMISTRY. A. Cantarow and M. Trumper. W. B. Saunders Co., Philadelphia, 5th ed., 1955, 738 pp.

This standard text is probably the most comprehensive work available on the clinical interpretation of biochemical laboratory findings. The present edition has been revised extensively to incorporate new material and concepts introduced in the six-year period intervening since the appearance of the fourth edition. Emphasis throughout is on clinical application; this is not a book on "methods" nor on the "fundamentals" of biochemistry.

Approximately the first half of the book approaches the subject from the standpoint of chemical entities with chapters on the metabolism of carbohydrates, lipids, proteins, nucleic acids, hemoglobin and porphyrins, calcium and phosphorus, magnesium, iron, sulfur, iodine, and sodium, potassium and chloride. Intermediate chapters deal with water balance, acid-base balance, respiratory exchange and basal metabolism, and an exceptionally complete discussion of hormone assay and endocrine function. Discussion of vitamins is limited chiefly to normal findings and methods for demonstration of deficiencies in man. The remainder of the text is functional in approach with chapters on gastric, pancreatic, hepatic and renal function. A final chapter discusses the biochemistry of spinal fluid.

One of the best features of Cantarow and Trumper is the complete index, comprising in the present edition no less than 99 pages. This, of course, greatly facilitates the ease of pinpointing the answer to a specific question. On the other hand, direct references to the original literature have now been replaced by brief lists of selected reviews and monographs on the more important topics. This will no doubt result in difficulty in locating original supporting data for some of the statements made.

This book is full of authoritative information. It is highly recommended as a valuable reference work to bridge the gap between basic biochemistry and clinical medicine.

WENDELL T. CARAWAY, Ph.D.

COLLINA, G.: Il problema del cancro visto dal medico pratico (The problem of cancer as seen by the general practitioner), Lega, Faenza, 1955

In this 463-page monograph, Collina offers to the general practitioner a remarkable ensemble work on cancer; a quick survey of practically all that has been recently done in the various specialized fields of research on the subject.

The book is divided into several sections: biology and experimental physiopathology, genetics, pathology, human chemistry, biochemistry and physiopathology, the psychology of cancer sufferers, the multitude of hypothetic etiologies, the prophylaxis and public assistance.

The book, while certainly valuable to the general practitioner in Italy, will also be of interest to the student outside Italy, because of its extensive reference to European and particularly Italian investigations which are usually out of reach of the English-speaking researcher. On this point it should prove to be a wealth of information.

The author discusses at length castration and hormone therapy, and adds the histories of twenty-seven personally followed cases so treated, with great success.

Skin cancer does not have a special chapter, but the use of podophyllin as well as the negative results of the ultrasonics in cancer of the skin are mentioned.

In regard to the attitude toward the cancer sufferer, Collina advises the family physician to "fasciare la veritá col dubbio scientifico" (cover the truth with the uncertainty of science). Even though (unfortunately) extremely rare, there are cases declared hopeless, in which the patient recovered for reasons unknown to science.

In regard to cytology, he agrees with the authors who believe this method gives an orientation toward a diagnosis only.

A most useful book for the practitioner and for those interested in foreign literature, and who are able to master the Italian language.

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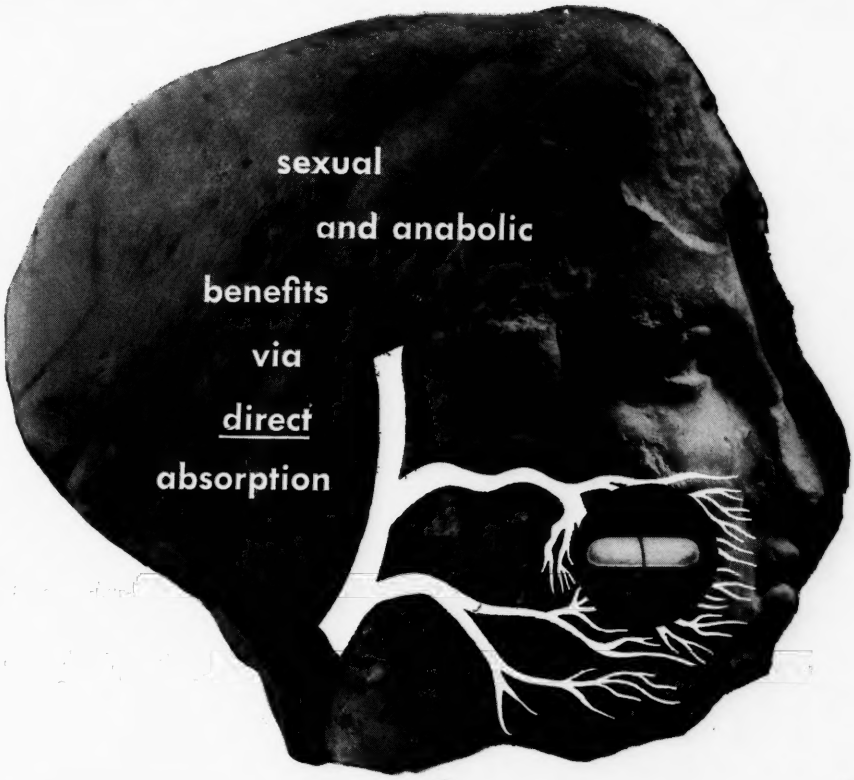

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Pedorella, Americo J., 242 Broadway, Providence 3 (Anes) ..... GA 1-8218
Pelletier, Emery, 120 Peace Street, Providence 7 ..... PL 1-4223
Penington, Robert, Jr., Cmdr., MC, USN, Bureau of Medicine and Surgery, Navy Department, Washington, D. C.
Perry, Thomas, Jr., 154 Waterman Street, Providence 6 (S) ..... DE 1-1717
Pesare, P. Joseph, 1250 Smith Street, Providence (Prev. Med) ..... EL 1-3721
Peters, Richard Lee, 980 Reservoir Avenue, Cranston ..... ST 1-4216
Petrucci, Ralph J., (*Bristol*) 88 Child Street, Warren ..... CH 5-3311
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*Pianka, Wallace J., Barnes Hospital, Vancouver, Washington
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Pierik, Michael G., 250 Elmwood Avenue, Providence (I) ..... GA 1-5455
Pinault, William N., (*Pawtucket*) 831 Newport Avenue, Pawtucket ..... PA 2-8474
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Porter, Emery M., 454 Angell Street, Providence 6 (S) ..... PL 1-2440
Porter, Lewis B., 199 Thayer Street, Providence 6 (OALR) ..... GA 1-3970
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Pozzi, Gustave L., 209 Waterman Avenue, East Providence 14 ..... EA 1-0330
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Pritzker, Samuel, 26 Alfred Stone Road, Providence 6 (Anes) ..... GA 1-1221

Q

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R

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Riemer, Robert W., 183 Angell Street, Providence 6 (S) ..... DE 1-8280
Riley, Clarence J., 507 Manton Avenue, Providence 9 ..... TE 1-2300
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Ronchese, Francesco, 170 Waterman Street, Providence 6 (D) ..... GA 1-3004

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Sweeney, John W., 191 Princeton Avenue, Providence 7 ..... HO 1-5078
Sweet, Gustaf, 105 Waterman Street, Providence 6 (I) ..... GA 1-1979
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V

Valentino, Angelo G., 354 Broadway, Providence ..... DE 1-2621
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W

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Williams, Harold W., 129 Waterman Street, Providence 6 (PN) ..... UN 1-0459
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Wing, Elihu S., 155 Thayer Street, Providence 6 (I) ..... GA 1-3314
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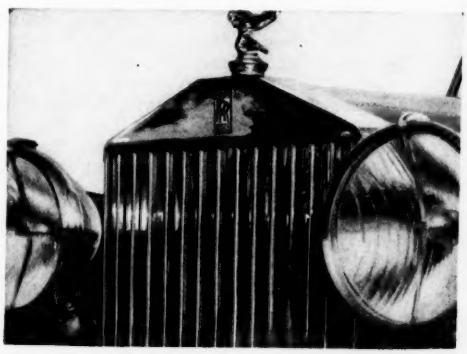

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AMA Clinical Session . . . at Boston . . . November 29 – December 2

AMA CLINICAL SESSION AT BOSTON

November 29 . . . December 2

THIS YEAR'S American Medical Association clinical meeting in Boston November 29 through December 2 is expected to be the largest ever held, the A.M.A. has announced.

The postgraduate education meeting, aimed at helping to solve the daily practice problems of the family physician, is expected to be attended by some 4,000 persons, a large increase over last year's meeting. About 200 scientific papers and exhibits have been scheduled for presentation, according to Doctor Thomas G. Hull, secretary of the A.M.A.'s Council on Scientific Assembly.

Meetings will be held in Mechanics Hall and at the Statler Hotel where the House of Delegates, the A.M.A.'s policy-making body, will hold sessions. Papers will be given in three lecture halls, offering the physician a wide variety of choice in subjects.

This ninth clinical session has been planned with the co-operation of organized medicine throughout all the New England States. Area medical societies have relinquished many meetings this year in order to give more time to the clinical session. General chairman for the meeting is Doctor Frank P. Foster, and Doctor Theodore L. Badger is program chairman. Both are from Boston.

Among the 100-plus scientific exhibits scheduled will be displays on fractures and deliveries. The obstetrical section will include manikin demonstrations of deliveries. Leading surgeons and obstetricians will be availaible for individual problem discussions.

Closed circuit television programs, originating in New England Deaconess hospital, will bring live operations in color to the lecture hall. The program is again being sponsored by Smith, Kline and French Laboratories of Philadelphia.

More than 50 motion pictures will be shown during the meeting, in the Paul Revere Annex of Mechanics Hall. A new medical film will be premièred at a special program at 8 P.M., Wednesday, Nov. 30, in the Georgian Room of the Statler Hotel. Following the première will be a special film and discussion on Total Right Hepatic Lobotomy by Doctors George T. Pack and Richard D. Brasfield, Memorial Hospital, New York City.

The technical exhibit will have more than 150 displays by medical equipment and pharmaceutical manufacturers, food processors, medical book publishers and other commercial organizations.

The General Practitioner of the Year will be named during the meeting. Last recipient of the award, chosen in Miami, was Doctor Karl Pace of Greenville, S. C.

An entertainment sidelight of the meeting will be a special concert for registrants by the Boston Symphony on Thursday, Dec. 1. Tickets will be given at the registration desk in Mechanics Hall, courtesy of Winthrop Stearns, Inc., New York pharmaceutical house.

BOOK REVIEWS

CHRISTOPHER'S MINOR SURGERY. Edited by Alton Ochsner, M.D. F.A.C.S. and Michael E. DeBakey, M.D. F.A.C.S. Seventh edition, W. B. Saunders Co. Phil., 1955. $9.00

This new edition of a surgical classic should prove a valuable reference for any doctor whose patients require surgery. It has been completely revised and rewritten. In modernization the high standards of previous editions have been maintained and in many instances surpassed. The authors of the various chapters include such authorities as Drs. Cooley, DeBakey, Lyons, and Ochsner with a heavy representation from the Tulane and Baylor schools of medicine. The scope of the material has been extended to include almost all surgery which does not involve entry of a major body cavity. The conditions are arranged by system and by region. Pathology, diagnosis, and the techniques of therapy are discussed clearly, concisely, and authoritatively with ample illustration. The procedures described vary from those that may be reasonably performed in the office or clinic, to those requiring the services of a well-equipped operating suite. The details of pre- and post-operative care are emphasized, as well as the techniques of operation. Since such a wide range is covered with such lucidity this text should occupy a prominent and often consulted position in any medical library.

PAUL B. METCALF, JR., M.D.

MEETINGS AHEAD

Monday, November 7 . . .

PROVIDENCE MEDICAL ASSOCIATION at the Medical Library, 8:30 P.M.

HARRY C. SOLOMON, M.D., Professor of Psychiatry at Harvard Medical School, speaks on

"PSYCHIATRY . . 1955 Model"

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Wednesday, November 9 . . .

JOHN F. KENNEY MEMORIAL CLINIC DAY, at Memorial Hospital, Pawtucket

(See page 570 for complete program)

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Wednesday, November 16 . . .

DIABETES FAIR at Miriam Hospital

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Monday, November 28 . . .

A.M.A. PUBLIC RELATIONS CONFERENCE at Boston

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Tuesday, November 29 through Friday, December 2 . . .

CLINICAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION at Boston

(See preceding page for information)

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